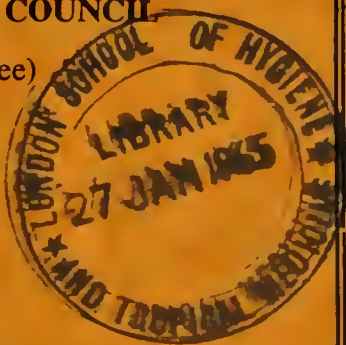


CUMBERLAND COUNTY COUNCIL

(Education Committee)



# *Annual Report*

on the

*School Health Service*

*For the Year 1962*

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B., M.R.C.S.,  
L.R.C.P., D.P.H.

PRINCIPAL SCHOOL MEDICAL OFFICER



**CUMBERLAND COUNTY COUNCIL**

(Education Committee)

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# **ANNUAL REPORT**

on the

**SCHOOL HEALTH SERVICE**

**FOR THE YEAR 1962**

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**JOHN LEIPER, M.B.E., T.D., M.B., Ch.B., M.R.C.S.,  
L.R.C.P., D.P.H.**

**PRINCIPAL SCHOOL MEDICAL OFFICER**

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## PREFACE

To the Chairman and Members of the Education Committee:

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the School Health Service for 1962.

The general state of fitness of school children in the County continues at a now familiar high level, and the number of children reported during the year as being unsatisfactory at medical examination is insignificant.

An account is given in the report of plans for the early introduction of a selective type of medical examination in the southern part of the County, and as this report is being completed this arrangement has in fact commenced. I look forward to reporting initial impressions of this reorientation of school health work in my next annual report.

It will be noted that a reorganisation of school clinic work has taken place during the year, and sessions which were attended by very few children have now been eliminated.

Much thought and action has been devoted during the year, towards making more definite plans for the earlier ascertainment of pre-school children who may have physical, mental and emotional handicaps.

The basis of this ascertainment lies in the formation of an 'At Risk' register, information being collated in the main shortly after the birth of children who may possibly later show handicaps which, during their school life may even entail special educational treatment. A number of such handicapped pupils will be children who have a defect of hearing, and it is amongst this group that extra care and organisation has occurred during the year to ensure the earliest ascertainment in the pre-school years.

The audiology service, already one of which we are especially proud in West Cumberland, has been extended



by the appointment of an audiometrician in East Cumberland and at the time of writing this report it is hoped that the establishment, which has now been increased to include a teacher of the deaf in East Cumberland, will shortly be filled.

There has been a further extension also of the Health Visitor/School Nurse secondment to General Practitioner groups, which has eased the way in many of the problems associated with the school child.

As a matter of fundamental importance, Health Education has been pursued actively by all school medical officers and nursing staff, and they have taken special action in making known the dangers to health associated with the smoking of cigarettes. Although much has been done in the County, I feel that until a nation-wide propaganda campaign is launched more nearly matching the commercial effort which continues to encourage smoking, then no very substantial advance can be made in this most difficult field of Health Education. It is interesting to notice in passing that the use of Further Education Centres by discussion groups on the subject of giving up smoking may well prove more rewarding than the association of such groups with clinics.

The difficulty associated with the establishment of two orthoptists in the County has again been only too marked, and for some three-quarters of the year unfortunately there was no-one in post. The solution to this problem seems to be a further effort to ensure that the career prospects of this rewarding work with children can be made known to suitable grammar school children.

It is gratifying that a large proportion of the educationally subnormal school leavers who have already been followed up by the arrangements mentioned in last year's report, have shown that they have been able to cope quite adequately in an adult world with the support of the social services.

Much thought has been given to the possibility of furthering the orthodontic work of the School Dental Officers in conjunction with the Hospital Consultant Orthodontic Service

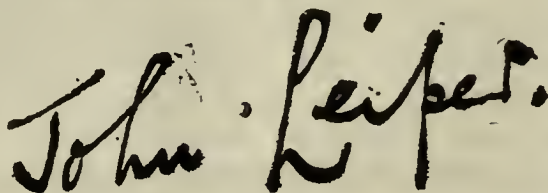
centred on the City General Hospital, Carlisle. Discussions have taken place between Mr. Neal and Mr. Roberts, the Consultant Orthodontist, and appropriate arrangements made for a suitable course to take place commencing early in 1963.

From colleagues in general and hospital practice, I have once again received much co-operation, and of particular continuing value is the link with Dr. Platt, Consultant Paediatrician.

I wish to thank all who helped with the preparation of this report, especially my Deputy, Dr. Terrell. The high standard of work of all members of the Health Department has continued to be invaluable.

I am, Mr. Chairman, Ladies and Gentlemen,

Your obedient servant.

A handwritten signature in dark ink, reading "John Leiper". The script is cursive and fluid, with the first name "John" and the last name "Leiper" clearly distinguishable.

Principal School Medical Officer.

County Health Department,  
11 Portland Square,  
Carlisle.  
May, 1963.



# SCHOOL HEALTH SERVICE

STAFF AS AT 31.12.62

## SCHOOL MEDICAL AND DENTAL STAFF

### Principal School Medical Officer—

\*John Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S.,  
L.R.C.P., D.P.H.

### Deputy Principal School Medical Officer—

\*J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

### School Medical Officers—

\*John Neil Dobson, M.B., Ch.B., D.P.H.

John R. Hassan, M.B., Ch.B., D.R.C.O.G.  
(Part-time General Practitioner).

\*James L. Hunter, M.B., Ch.B., D.P.H.

\*Thomas F. M. Jackson, L.R.C.P., L.R.C.S., L.R.F.P.S.,  
D.P.H. Resigned 2.11.62.

\*Harry C. T. Smith, M.B., Ch.B., D.P.H., D.P.A.

\*John Patterson, M.B., B.Ch., B.A.O., D.P.H.

\*Kenmure J. Thomson, M.B., Ch.B., D.P.H.

The above are also District Medical Officers of Health  
and Assistant County Medical Officers.

Alix B. C. Halliday, M.B., Ch.B. Resigned 30.9.62.

\*Enid M. O. Campbell, M.B., Ch.B., D.P.H.

\*Catherine Helen Mair, L.R.C.P., L.R.C.S. (Ed.), D.P.H.

\*Elizabeth M. Spencer, M.B., Ch.B.

\*Approved for the ascertainment of educationally sub-  
normal pupils.

**Principal School Dental Officer—**

R. B. Neal, M.B.E., L.D.S.

**School Dental Officers—**

J. A. G. Baxter, L.D.S., Commenced 1.7.62.

I. R. C. Crabb, L.D.S.

D. H. Hayes, L.D.S.

Mrs. M. Hayes, B.D.S.

F. H. Jacobs, L.D.S.

A. MacDonald, L.D.S.

I. H. Parsons, L.D.S. Commenced 4.6.62.

A. R. Peck, L.D.S.

J. G. Potter, L.D.S.

A. M. Scott, L.D.S.

J. Watson, B.D.S., L.D.S. (Resigned 30.4.62)

**MEDICAL AUXILIARY STAFF**

**Orthoptist—**

Miss J. Modlin, D.B.O. Resigned 1.4.62.

**Orthopaedic Physiotherapists—**

Miss J. A. Fraser, M.C.S.P., O.N.C.

Miss J. M. Morris, M.C.S.P., M.E.

**Speech Therapists—**

Miss C. M. Allan, L.C.S.T.

Mrs. E. M. Blacklock, L.C.S.T.

Miss E. B. Moon, L.C.S.T.

**Audiometricians—**

Mrs. M. G. Hicks.

Miss R. Thompson. Commenced 29.10.62.

## NURSING STAFF

### **Superintendent Nursing Officer—**

Miss I. Mansbridge, S.R.N., S.C.M., Q.N., H.V.Cert.

### **Deputy Superintendent Nursing Officer—**

Miss M. Blockey, S.R.N., S.C.M., Q.N., H.V.Cert.

### **Assistant Superintendent Nursing Officers—**

Miss P. G. O'Sullivan, S.R.N., S.C.M., Q.N., H.V.Cert.

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V.Cert.

Miss M. G. M. Watson, S.R.N., S.C.M., Q.N., H.V.Cert.

Commenced 8.10.62.

### **School Nurses—**

#### **Full-time—**

Mrs. E. Knudtson, S.R.N., Workington.

Mrs. E. M. Maguire, S.R.N., S.C.M., O.N.C., Whitehaven.

Miss D. Wise, S.R.N., S.C.M., Q.N., R.F.N., Workington.

Mrs. B. F. Wilson, S.R.N., Whitehaven.

#### **Part-time—**

Mrs. E. C. Barnes, S.E.N., S.C.M., Lanercost.

Miss M. A. Barclay, S.R.N., S.C.M., Q.N., S.R.F.N., Greystoke.

Miss A. Bowler, S.R.N., S.C.M., Q.N., H.V.Cert., Caldbeck.

Miss J. Byres, S.R.N., S.C.M., Q.N., High Hesket.

Miss A. Cockton, S.R.N., S.C.M., Q.N., S.R.F.N., Burgh by Sands.

Miss E. M. Chalkley, S.R.N., S.C.M., Q.N., Langwathby.

Miss A. Dixon, S.R.N., S.C.M., H.V.Cert., Penrith.

Miss L. R. Douglass, S.E.N., S.C.M., Skelton.

Mrs. F. A. Gaskin, S.R.N., S.C.M., Q.N., Irthington.

Miss C. H. Greaves, S.R.N., S.C.M., Lazonby.

Miss M. Hastings, S.R.N., S.C.M., Q.N., H.V.Cert., Houghton.

Mrs. M. Hedworth, S.R.N., S.C.M., Q.N., Abbeytown.

- Miss E. Henderson, S.R.N., S.C.M., Q.N., Langwathby.  
 Miss B. W. Knibbs, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Brampton.  
 Mrs. D. M. Lancaster, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Wigton.  
 Mrs. M. J. Matthews, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Watermillock.  
 Mrs. A. W. E. Maughan, S.R.N., S.C.M. (Pt. I),  
 H.V.Cert., Longtown.  
 Miss E. Mercer, S.R.N., S.C.M., H.V.Cert., Wigton and  
 Silloth.  
 Mrs. M. McCredie, S.R.N., S.C.M., H.V.Cert., Penrith.  
 Miss F. McGrath, S.R.N., S.C.M., Q.N., Dalston.  
 Mrs. M. C. Roberts, S.R.N., S.C.M., H.V.Cert.,  
 Aspatria.  
 Mrs. E. E. Rome, S.E.N., S.C.M., Kirkbride.  
 Miss N. D. Sanderson, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Bewcastle.  
 Miss B. M. Wesson, S.R.N., S.C.M., Q.N., Hayton.  
 Miss M. Weightman, S.R.N., S.C.M., Q.N., Scotby.  
 Miss E. M. Wallace, S.R.N., S.C.M., Q.N., Wetheral.  
 Miss M. Worrell, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Alston.
- Miss I. Arnott, S.R.N., S.C.M., Q.N., Threlkeld.  
 Mrs. C. Butcher, S.R.N., S.C.M., Q.N., Bassenthwaite.  
 Miss M. Casey, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Keswick.  
 Mrs. A. Donald, S.R.N., S.C.M., Q.N., R.S.C.N.,  
 Oughterside.  
 Miss S. J. Graham, S.E.N., S.C.M., Brigham.  
 Miss J. M. Hillhouse, S.R.N., S.C.M., Keswick.  
 Mrs. N. Hodgson, S.E.N., S.C.M., Broughton.  
 Miss A. R. Hobbiss, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Lorton.  
 Miss M. Horn, S.R.N., S.C.M., H.V.Cert., Cocker-  
 mouth.

Miss S. M. J. Iliffe, S.R.N., S.C.M., Q.N., Borrowdale.  
 Miss F. Kendall, S.R.N., S.C.M., H.V.Cert., Maryport.  
 Miss C. F. M. McKnight, S.R.N., S.C.M., Q.N.,  
 H.V.Cert., Dearham.  
 Miss S. Twigg, S.R.N., S.C.M., H.V.Cert., Maryport.  
 Miss R. W. Ventress, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Bothel.

Miss I. M. Alcock, S.R.N., S.C.M., H.V. Cert., White-  
 haven.  
 Mrs. S. Bowe, S.R.N., S.C.M., H.V.Cert., Whitehaven.  
 Mrs. I. E. Bowe, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Bootle.  
 Miss E. Crosby, S.R.N., S.C.M., H.V.Cert., Egremont.  
 Mrs. J. A. Graham, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Distington.  
 Miss A. M. Greggain, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Frizington.  
 Miss J. Hardie, S.R.N., S.C.M., Q.N., H.V.Cert., Parton.  
 Miss D. D. James, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Seascale.  
 Miss A. M. Little, S.R.N., S.C.M., H.V.Cert., Millom.  
 Miss R. Lodge, S.R.N., S.C.M., H.V.Cert., Whitehaven.  
 Mrs. M. Marshall, S.R.N., S.C.M., Q.N., Muncaster.  
 Mrs. A. Petch, S.R.N., S.C.M., Q.N., H.V.Cert., White-  
 haven.  
 Miss R. Sheppard, S.R.N., S.C.M., Q.N., H.V.Cert.,  
 Cleator Moor.

#### **Dental Surgery Assistants—**

Miss J. G. Benson.	Miss K. E. Lowes.
Miss O. Bird.	Mrs. E. Hocking.
Miss A. Blamire.	Mrs. S. F. Kerr.
Mrs. M. Byers.	Mrs. W. F. Reeves.
Miss J. E. Harrison.	Mrs. B. E. Robinson.
Miss M. I. Stout.	

## GENERAL STATISTICS

The area covered by the Local Education Authority comprises 967,054 acres and the estimated population of the Administrative County in June, 1962, was 223,330.

The number of pupils on the school registers in January, 1963, was 37,768, compared with 38,143 in the previous year, a decrease of 375.

In January, 1963, there were in the county:—

		No. of pupils
Nursery school ... ..	1	40
Primary schools ... ..	247	22,426
Non-selective secondary schools ... ..	24	9,746
Grammar schools ... ..	9	5,149
Secondary technical school ... ..	1	314
Residential special schools ... ..	2	
(One for educationally subnormal boys, age range 9-16 years) ... ..		57
(One for educationally subnormal girls, age range 9-16 years) ... ..		36
		<hr/> 37,768 <hr/>

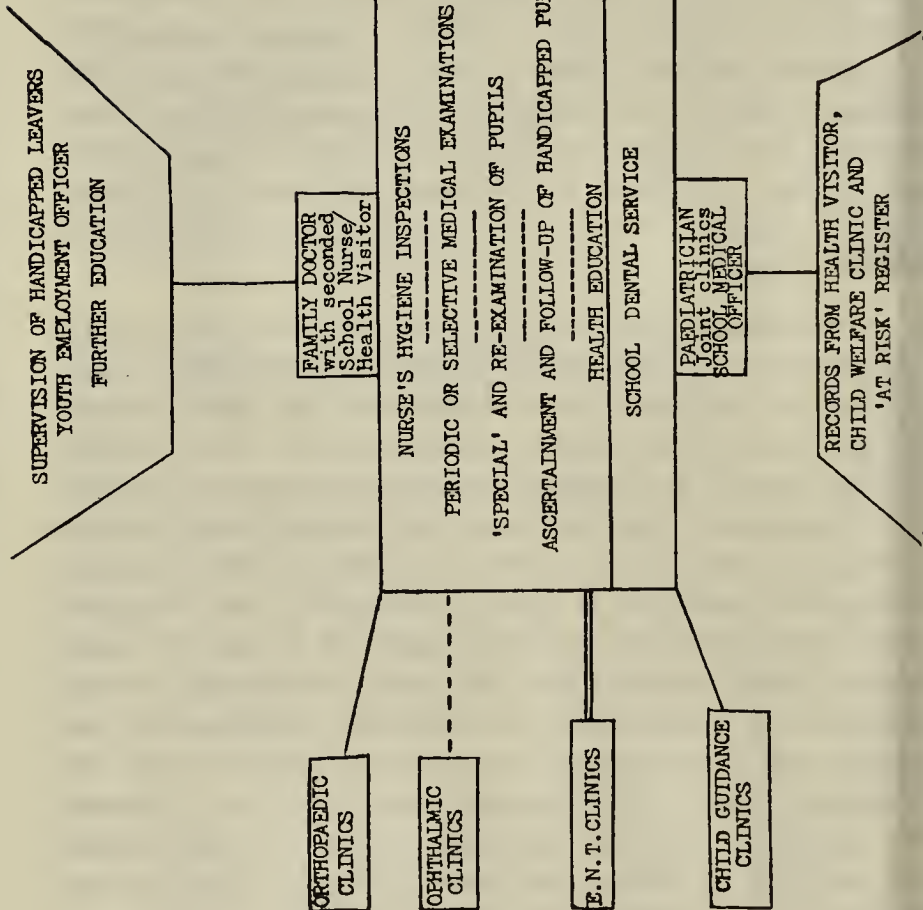


## THE PATTERN OF THE SERVICE

The School Health Service throughout its history of over fifty years duration has had as its fundamental purpose the prevention of ill health in school children and the earliest possible detection of signs of departure from the normal in childhood development. When serious and disabling defects were the order of the day in a large proportion of children, only a comprehensive screening of all school children as often as was practicable during school life could hope to deal adequately with the volume of work in diagnosis and remedial treatment. Gradually, the special services, such as speech therapy and orthoptics, developed on the one hand and a comprehensive range of specialist and consultative clinics on the other, the principal source of referral being the School Medical Officer working closely with the School Nurse. Within this setting the School Medical Officer became both the main guardian of the school child's health, as well as a specialist in his health problems in the school setting, especially where a permanently handicapping condition existed.

Both the progressive improvement in child health and the development of the health services in this country have shifted the emphasis over the years in the various aspects of the work of the School Health Service. The National Health Service Act provided comprehensive medical care for old and young for the first time and, relinquishing treatment entirely to the family doctor, the School Health Service became an even more purely preventative and diagnostic one concentrating on the relationship of the school to the child's health problems and vice versa; increasingly focusing attention on handicapping or potentially handicapping conditions and taking every opportunity both with parents and children in both individual and group situations to advance the principles of health education. Meanwhile, the frontiers of detection of defects and abnormalities in childhood are being pushed steadily back into the infancy and even pre-natal periods and the fusion of thought and approach to

# THE SCHOOL HEALTH SERVICE



SPECT  
SERV

SPECIALIST  
CLINICS

child health problems right from birth through to maturity became increasingly necessary. This trend was, of course, clearly indicated in many provisions of the School Health Service in the Education Act, 1944, embracing children from the age of two years.

This changing pattern of health and health services for children has inevitably occasioned much thought with regard to the most effective distribution of the time and effort of the school doctor and school nurse, and I hope that some of the topics discussed later in this report, notably the future form of medical inspection and school clinic services, the significance of an "At Risk" register for pre-school children and secondment of Health Visitor/School Nurses to General Practitioners, will be considered against the background which has been sketched above. I have tried on the attached sheet to show semi-diagrammatically the form of the School Health Service and its relationship to the other branches of the health services.



### **The Examination of School Children**

The chief activity upon which the various aspects of the school health service has thus been traditionally based and for very good reasons, has been the routine medical inspection of all school children at three times during school life. Until the 1953 School Health Service and Handicapped Pupils Regulations made provision for modifications, not necessarily involving three examinations for each child, this latter pattern was a statutory responsibility upon Local Education Authorities. The 1953 Regulations were further amended in 1959 so that a wide variety of experimentation was possible with different approaches to the medical examination of school children and already it was apparent that the most useful direction of change was towards a selective type of examination after an initial screening by full examination of all entrants in their first year at school. A number of authorities came into this field of experiment

early and their experience to date has both confirmed the effectiveness of a selective type of examination and pointed to the main snags and difficulties which have to be overcome. Having considered the subject fully in relation to the situation in Cumberland, I have felt that the time was ripe to introduce a selective type of medical examination between school entry and leaving in one area of the county. For various reasons, both administrative and connected with the state of development of services such as audiology, the southern area of the county was chosen and, with the co-operation of Mr. Bessey, the Director of Education, and his staff, arrangements are now well advanced to commence the selective examination in the summer term of 1963. The following notes give a broad picture of how the scheme will work.

It is proposed that the scheme should operate broadly as follows in the chosen area. The present termly visit by the school nurse for the purpose of a hygiene inspection will be increased in significance by the attendance also of the school medical officer, at least for part of the time of the nurse's visit. This visit will be arranged with the head so that he or she can confer with the doctor and nurse on the selection of children to be examined that term. An appointment will be made for the school medical officer and nurse to return to examine the selected children. When each child reaches 8 years of age, and again at 12, a questionnaire will be issued to the parents which asks for full information about the child's health background, and it has been felt advisable to provide an envelope marked "confidential" for this to be returned by the parents to assist in the selection procedure. An annual test of the vision of each child will be a further aim and the screening of the hearing of all school entrants will continue as at present. Within this framework also will be contained the regular and indeed more frequent follow-up of handicapped children.

Dr. Spencer, one of the school medical officers who will operate this new scheme, writes as follows in anticipation of the new arrangements:—



“The aim is to cut out unnecessary examinations of healthy children at 9-10 years of age, and concentrate on closer contact with those who have defects likely to hinder their education.

The new school entrants will be examined as usual at 5 years old and any defects found suitably followed up. The school will be visited by a medical officer every term, when the health problems of any pupil can be brought to the doctor's attention by the head teacher or parent. (Here it must be stressed that it is better to bring forward ten children for examination who turn out to have no defect, than to miss one who has.)

The school leaving examination at 13-14 years will be conducted as usual, and the eyesight of every child will be tested once a year.

When each child is 8 and again 12 years old, a questionnaire will be sent to the parents about the health and wellbeing of their child, and any child who appears, from the answers, to have a health problem, will be fully examined.

The parents are requested to attend all examinations as they can give so much more information about any illness”

### **Examination Findings, 1962**

During the whole of 1962, however, the three routine medical inspection pattern was maintained and every effort made to see that as many schools as possible were visited, thus bringing up to date medical inspection work which has inevitably suffered in recent years in the face of urgent immunisation and vaccination work, notably the various phases of the polio vaccination scheme and the introduction of tetanus protection for school children. The table and graph following show the proportion of defects found and of children deemed ‘unsatisfactory’ by the school medical officers.

Year	Total Periodic Examinations	Total Pupils found to have Defects	%	Total found with unsatisfactory physical condition	%
1962	12,547	1,078	8.5	2	0.02
1961	8,754	715	8.2 (15.51)	9	0.10 (0.68)
1960	9,633	915	9.5 (15.99)	50	0.51 (0.85)
1959	9,985	1,072	10.7 (15.76)	71	0.71 (1.14)
1958	10,887	1,286	11.8	97	0.89
1957	10,864	1,302	11.9 (14.98)	132	1.22 (1.72)
1956	9,783	1,352	13.8	247	2.52

The figures shown in brackets are the available comparative figures for England and Wales.

It will be seen from the above table and graph that considerable progress was made in 1962 in bringing up to date the medical examination of the "routine" groups in schools. Every school in the county, except one, was visited during the year in examining the 12,547 children. The percentage of pupils showing defects is tending to settle at a figure which is considerably lower than that for England and Wales, while the number found to be "unsatisfactory" has practically disappeared. This latter fact shows, I think, that even where defects or handicaps are known to be present, the care and supervision is comprehensive and "satisfactory."

The secondment of school nurse/health visitors to work with general practitioners has been extended further in 1962 so that now 9 of these nurses are operating in this way and serving a total of 31 general practitioners. Every promise of success in this scheme has been fulfilled and each new school nurse who begins to work in this close conjunction with general practitioners immediately proves the substantial advantages of the arrangement.

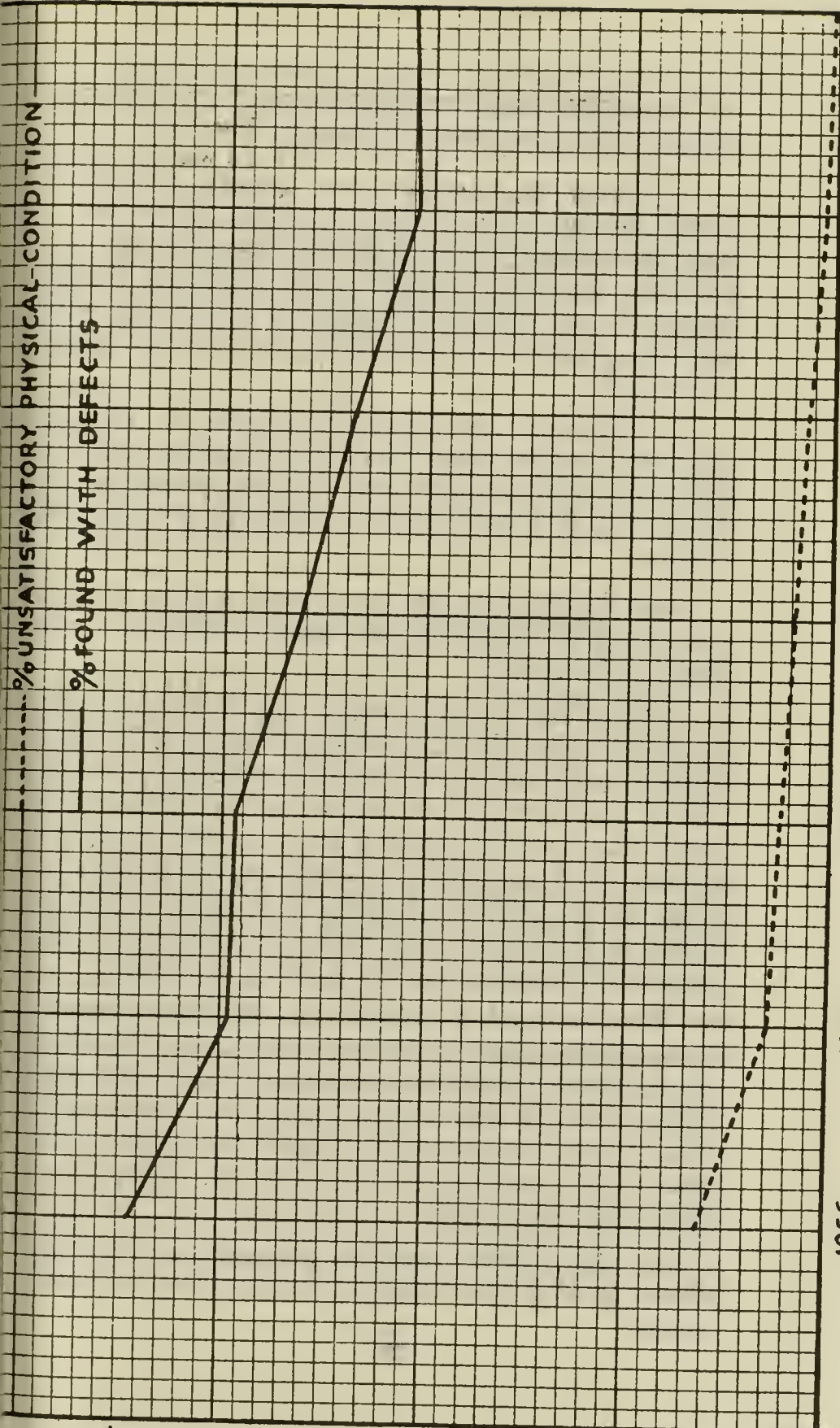


----- % UNSATISFACTORY PHYSICAL CONDITION

—— % FOUND WITH DEFECTS

14  
12  
10  
8  
6  
4  
2

1956 1957 1958 1959 1960 1961 1962



One of the school nurse/health visitors who came into this field during 1962 writes as follows:—

“The practice to which I am seconded comprises 4 general practitioners and covers the whole of my district. I am able to discuss with them problems, including behaviour difficulties, brought forward by head teachers at hygiene inspections, e.g. signs of insecurity, the poorly clad, tired child, etc., and find out more about the home and family background.

In cases which the doctors are treating, e.g. impetigo and some infectious diseases such as measles, chickenpox, I am asked to visit and ensure that treatment is being carried out, as well as to give advice on preventing the spread of infection.”

Mrs. Wilson, a full-time school nurse in West Cumberland, writes as follows on her work in connection with medical inspections:—

“A few days before a medical inspection, nurse takes the medical cards to school. She proceeds to test the visual acuity of each child due for medical examination and also puts the appointment papers with the corresponding medical cards. She attends the medical inspection with the School Medical Officer and during the inspection is responsible for seeing that the children are undressed as necessary, and go forward to doctor in a correct order. If parents are present, they are kept waiting as short a period as possible.

Visits are paid to schools with the doctor for the purpose of diphtheria, tetanus, poliomyelitis and tuberculosis immunisations. Generally, parents are willing to have their children protected, but in the case of refusal it is again the school nurses' duty to see the parents and point out the dangers to the unprotected child. This will perhaps mean several visits to the home.

In being a school nurse the rewarding part is to see normal, healthy, clean children running round the playground.”

Such full-time school nurses are employed only in the main areas of population and they link closely with the health visitors, as indicated by Miss Alcock, a seconded health visitor:—

“In many instances the school nurse and health visitor work together in school health work and in my experience this is a happy association. Indeed, the school nurse takes over quite a lot of the routine inspections, leaving the health visitor more time for selected home visits and health education.

The health visitor has access to the family doctor and discusses those children brought to her notice by the school nurse and any the family doctor wishes to keep under special observation at school.”

### **Height and Weight of School Children**

Early in 1961, the Ministries of Health and Education decided that there was a need for a more detailed picture of trends of growth of school children as regards height and weight, and approached the local health authorities in a dozen different areas of the country, inviting their co-operation in an investigation.

It appeared that since 1951 there had been a more or less steady fall in the intake of protein by the nation as a whole, and large families appeared to be in a less satisfactory position than others. If this trend continued, a point would ultimately be reached when malnutrition would result, and the first demonstrable effect of such malnutrition would, according to the experts, take the form of a check to growth. Thus, it was felt that fuller information about the growth of children in large families was required.

This was the purpose of the proposed survey which would last for five years, and would be concerned with boys and girls in their sixth year of life who were only children,

and also those in families with three or more siblings either at school or under school age. The same groups would apply to boys and girls aged 14-15 years.

The groups of only children were included because some "control" standard comparison was needed. It was emphasised that the investigation was not a research project; rather the aim was to modify the existing procedure at routine medical examinations, so as to provide an "alarm bell" which would ring at an earlier stage than it normally would.

Cumberland was one of the areas selected for this survey, and after preliminary discussions with the school nurses concerned regarding the procedure to be adopted, the survey commenced in the autumn term of 1961, and has continued during 1962. The first results covering the period between the summer term of 1961 and the spring term of 1962 were published early in 1963 and showed, with almost uniform consistency, that both heights and weights were found lower on average in the large family groups. It is proposed to analyse the data more fully at a later stage, and it will be interesting to note the trends over the next few years.

### **Hygiene Inspection**

The school nurse makes termly visits to each school to carry out a hygiene inspection, a visit which, as will be seen above, is now indeed forming the basis of the selective procedure for intermediate medical examinations. The feature of these hygiene inspections which tends to attract most attention and comment is the screening of children for possible infestation with lice or "nits." This is, however, only one aspect of the matter, for observation of the general physical and nutritional condition of each child with attention to posture, gait and general demeanour has often led the nurse to look into home or other circumstances, often in close co-operation with the teaching staff, which may be playing adversely onto the child. Mrs. Wilson writes as follows on this part of her school work:—



"In the West Cumberland area a special effort has been made over the past 2 years to improve on the personal cleanliness of school children and to reduce infestation figures.

Hygiene inspections are carried out by nurse at the beginning of each term in order to inspect each child's hair, clothing and general cleanliness, and note is made of any obvious defect or condition which requires medical attention. Following these inspections a home visit may be made to advise the parents to take the child to the family doctor for treatment.

In the event of a child having head lice or nits, a note signed by the County Medical Officer is at present sent to the parent. Nurse then visits the homes of these children to try to encourage the parents to keep the children free of these 'pests.'

Following up full inspections, nurse visits the school, if possible weekly, to reinspect those children noted during the first visit.

Where a child has nits or lice and, even after home visits, the parent is doing little or nothing about cleaning the hair, permission from the parent is sought to take the child or children to the clinic for cleansing. Only occasionally will parents refuse to allow nurse to do this. In this case, frequent home visits and an ample supply of head lotion, shampoo and a steel comb encourage the parents to try to keep the child's hair in a better condition. If there are two school nurses in the area it is advisable to get together and take families to the clinic for hair cleaning. We have found in this area that some mothers will even allow us to clean pre-school children.

In secondary modern schools the children themselves can do and will do a great deal to help, but need weekly inspection and encouragement. Small clinics of 4 to 6 children, held after school hours, have been found effective.

It encourages them to clean each other's hair (especially in the case of sisters), and to make a special effort in some cases to keep their hair clean. These children are also coaxed to visit nurse at the clinic if they are ever again troubled, and also told they can collect shampoo or head lotion. They can also borrow steel combs from the clinic until they get their hair completely clean. It is impressed upon them that it is no disgrace to be infested by head lice, but it is a disgrace to keep them. Frequent talks are given to these children on personal hygiene, and appropriate leaflets are given to the girls in secondary modern schools to try to encourage cleanliness.

A most important point is to show parents (even in the case of weekly visits) that the nurse is not 'getting at them' but is really interested in their children.

It is equally important that nurse works in close harmony with the head teachers and with all teaching staff. The head teachers are interested in the work done and do appreciate the fact that nurse keeps them informed about the children.

If the child is sent to school wearing dirty clothing and obviously uncared for, here again a home visit is required and the parents are asked tactfully to send the child to school clean. Nurse can add, 'It seems rather unfair to the child to have to be sent out of class to wash as soon as he gets into school.' This remark, in my experience, is effective without being offensive.

Many defects are noticed by nurse during a cleanliness inspection and on the whole parents are relieved when nurse goes to talk it over with them and explain that the school doctor can examine their children and tell them in simple terms what has gone wrong and how it can be cured.

When it is apparent, or a report from a teacher suggests that a child has a vision loss, nurse should arrange for and encourage the parents to bring the child to the nearest clinic



for a visual acuity test. If a defect is found the school medical officer will advise the parents on having the child seen by an eye specialist.

In the senior schools, too, nurse will notice a few stained fingers due to smoking; she points out how damaging this is to health and also how much money it wastes."

With regard to the specific matter of infestation, the numbers of examinations carried out in the year and the number of "positives" (live lice or nits) found, are shown below together with the figures for the previous ten years.

Year	No. of examinations	No. of children found infested
1962	69,439	1,406
1961	79,007	1,269
1960	72,226	1,531
1959	86,790	998
1958	72,691	1,010
1957	76,513	1,029
1956	84,286	1,174
1955	108,491	1,085
1954	104,704	1,420
1953	108,309	953

The numbers of children showing evidence of live parasites or nits in their hair continue at a disturbingly high figure. The basic solution of this problem is mainly one of parental and family education, and a considerable amount of painstaking work by the nurses goes into this and the assisting of the parents in ridding the child of infestation. This is well brought out by Mrs. Wilson's account of her work given above.

The statutory procedure under Section 54 of the Education Act whereby parents can be compelled to cleanse an infested child or the child be cleansed by the authority's officer, can now be applied in the county. This measure is in mind, however, for only a minute but nevertheless significant minority where the persuasion and help of the

school nurse has repeatedly failed to secure any parental co-operation in the problem. The power of compulsion will, of course, be used sparingly and only as a last resort.

### *Employment of Children By-Laws*

The practice of examining children to ascertain their fitness for employment outside school hours was continued during the year. In all, 347 examinations were carried out, involving 306 children. The following table gives details.

<i>Examined for 1st time</i>	<i>Re-examined once</i>	<i>Re-examined twice</i>
273	66	8

Of the 273 children examined for the first time, only one was found to be unfit.

### **School Clinic Work**

The steady decrease in the numbers of cases seen at school clinics in recent years has prompted me to consider how best to deploy the time of the school medical officers and school nurses in catering for the type of consultation one normally associates with school clinics. A tendency has developed for a variety of tasks to accumulate for the school clinic session, such as missed vaccinations and immunisations, examinations of teacher-training college entrants, etc. A stage has been reached, however, when these were occupying a substantial part of the clinic session and they, as well as the 'genuine' school clinic cases, could quite conveniently and efficiently be seen before or after a child welfare clinic session in the smaller centres. Many of the school children who would normally be referred to a school clinic session for special or re-examination of, e.g. vision, could well attend at 4.15—4.30 p.m. and at the same time avoid loss of school time. It must also be remembered that as far as a large number of rural schools in Cumberland is concerned, it has never been possible to offer a regular school clinic facility because of distance and the school nurse, usually in such cases the local district nurse/health visitor, has visited the schools as required and made what

arrangements were necessary. Thus towards the end of the year I was satisfied that most regular doctor and nurse school clinic sessions should cease as such and the heads of schools be asked to apply directly to the school medical officer or nurse when cases arose requiring attention.

Convenient arrangements can then be made involving in some cases more frequent visits to the school by nurse or doctor, itself a sound trend. The school clinic buildings will be as fully at the service of school children as ever but will in fact be used at times not involving special school clinic sessions. This arrangement which operates from the beginning of 1963 is linked with the selective examination scheme in the southern area which will demand more school medical officer and nurse time than the present arrangement, and also with the screening procedure for 'At Risk' children in their pre-school life, described on page 54.

For 1962 I show the usual table giving the numbers of cases of various conditions seen at school clinics. Though some of the numbers appear formidable, when broken down by the number of clinics and sessions, the volume of work is such that it can be adequately dealt with as outlined above.

At the time of writing this report the new clinic building at Seascale is nearing completion and plans are prepared for a further new clinic at Salterbeck, Workington, work on which should be commenced in the spring of 1963. Further clinics which will serve the school health service for both dental and general work are planned within the next ten years for Brampton, Frizington, Moorclose (Workington), Cleator Moor, Maryport, Cockermouth, Tarraby, and Seaton, as part of the Authority's Ten Year Programme.

The school clinics available in 1962 are set out in Appendix "C" to the report. A total of 1,900 individual children attended the school clinics during the year. Attendances at individual clinics and the types of case are set out below.

Clinic					New Cases	Total Attend- ances
Aspatria	...	...	...	...	63	225
Brampton	...	...	...	...	107	187
Carlisle	...	...	...	...	19	45
Cleator Moor	...	...	...	...	48	182
Cockermouth	...	...	...	...	149	222
Egremont	...	...	...	...	37	60
Frizington	...	...	...	...	22	46
Keswick	...	...	...	...	21	22
Maryport	...	...	...	...	101	311
Millom	...	...	...	...	88	575
Penrith	...	...	...	...	37	51
Whitehaven (Mirehouse)	...	...	...	...	45	105
Whitehaven (Flatt Walks )	...	...	...	...	199	652
Whitehaven (Woodhouse)	...	...	...	...	169	366
Wigton	...	...	...	...	95	258
Workington	...	...	...	...	278	842
Parton	...	...	...	...	5	18
					<hr/> 1,483 <hr/>	<hr/> 4,167 <hr/>

# SCHOOL CLINICS

Defect Code No.	Conditions for which child attended	New Cases					Total Attendances						
		1962	1961	1960	1959	1958	1957	1962	1961	1960	1959	1958	1957
1.	Cleanliness	...	...	...	...	...	...	...	...	...	...	...	...
2.	Infestation	...	...	...	...	...	...	...	...	...	...	...	...
4.	Skin diseases	...	...	...	...	...	...	...	...	...	...	...	...
5.	Eye diseases	...	...	...	...	...	...	...	...	...	...	...	...
6.	Ear conditions	...	...	...	...	...	...	...	...	...	...	...	...
7.	Nose and throat conditions	...	...	...	...	...	...	...	...	...	...	...	...
8	Speech defects	...	...	...	...	...	...	...	...	...	...	...	...
9	Lymphatic glands	...	...	...	...	...	...	...	...	...	...	...	...
10.	Heart	...	...	...	...	...	...	...	...	...	...	...	...
11.	Lungs	...	...	...	...	...	...	...	...	...	...	...	...
12.	Developmental	...	...	...	...	...	...	...	...	...	...	...	...
13	Orthopaedic	...	...	...	...	...	...	...	...	...	...	...	...
14.	Nervous system	...	...	...	...	...	...	...	...	...	...	...	...
15.	Psychological	...	...	...	...	...	...	...	...	...	...	...	...
16	Abdomen	...	...	...	...	...	...	...	...	...	...	...	...
7.	Other conditions	...	...	...	...	...	...	...	...	...	...	...	...
		1483	1400	2202	2165	2353	3016	4167	3950	6728	6723	7580	9458



## **SPECIAL SERVICES**

### **Ear, Nose and Throat Conditions**

I am very grateful to Mr. Page, consultant Ear, Nose and Throat surgeon, for the following comments on the present-day ear, nose and throat clinic.

“The character of this clinic has changed remarkably over the past ten years. No longer are some 30 children ‘herded along’ to the laryngologist at each clinic in the mistaken belief that removal of tonsils and adenoids is the only effective means of eliminating recurrent upper respiratory infections. Antibacterial drugs, when adequately used, have been shown to eliminate most of the chronic ill-health that formerly resulted from such infections.

The clinic today deals with some 12 children at a time—predominantly deaf children—whose disability can usually be relieved to a great extent. The school health service plays an ever increasing part in the early detection of deafness. The nursing staff and health visitors, now specially trained in this type of work, are detecting cases of deafness in the pre-school age group so that even before such a child reaches school age he or she has been equipped with a hearing aid and received auditory training, minimising the handicap the child would otherwise have faced at a later date.

Routine periodic medical examinations and more recently, the audiometric sweep tests introduced into the school service should make it impossible for any child now to complete its first year’s schooling without such a disability being detected and alleviated to a greater or lesser degree. No longer should it be possible for any deaf child to be mistakenly placed in a school for backward children as occasionally happened in the past.

The majority of deaf children show only minor deafness. Moderately deaf children can be so helped by the teachers of the deaf, speech therapists and a really excellent service



from our hearing aid centres, that they remain educable in normal schools. Only some 20 children in the Cumberland area are severely enough handicapped by deafness to require education in special schools."

I have not shown this year a table of children who have had tonsillectomy. Over the past 5 years the percentage of children examined in school each year who have had their tonsils removed at some time has fallen slowly from 21.6 in 1957 to 15.9 in 1961. The 1962 figure is once again 17.9, thus reverting to that of 1960. This may well be accounted for, however, by the fact mentioned earlier in this report that a higher total number of children was examined in school in 1962 than in any year in the past 5 years.

The statistical information relating to diseases of the ear, nose and throat is set out in Table "A" and Table "B," Part II of Appendix A.

### **Provision of Hearing Aids**

The total number of pupils in the schools who are known to have been provided with hearing aids is 45, of whom 10 have been equipped during 1962.

### **Audiology Services**

The main advance in this important work during the year has been the commencement of an audiometry service in East Cumberland in anticipation of the appointment in 1963 of a further peripatetic teacher of the deaf. All school entrants, therefore, are now being tested by pure tone audiometry throughout the county, as well as all school children in whom there is any special indication such as inattention in class, educational retardation, or other relevant handicap. When a second teacher of the deaf is appointed the link-up will be complete with the scheme described in last year's report, whereby all babies are tested at about the age of nine months and any suspicion of hearing impairment

followed up through family doctor, hospital and education services as required. It is too early to assess the results of the audiometry of school entrants in East Cumberland since this was only in operation for the last four weeks of the autumn term of 1962. Dr. Hunter has, however, again supplied the 1962 instalment of the audiology story in West Cumberland, commenced in 1959.

“In West Cumberland the ascertainment and follow-up of impaired hearing in the infant and in the school child followed the same pattern in 1962 as in previous years, that is to say, simple testing in the home and clinic by the health visitor for pre-school children, routine audiometric testing of school entrants, and the testing of special cases brought forward for various reasons. From the infant group one significantly deaf child only was discovered.

The work of the trained audiometrician in tests of routine and special cases is given in Table 1. These figures relate only to school children.

Table 1 — Pure-tone Audiometry — 1962

Number tested in routine group	...	2,451	
(i.e. children born in 1956 and 1957)			
Number with hearing loss	...	127	(5.2%)
Number specially referred	...	173	
(i.e. in all school age groups)			
Number with hearing loss	...	74	(42.8%)

Of those specially referred, 96 were brought forward by school medical officers, 22 by parents, 15 by head teachers, 5 by family doctors and one by the otologist. The remaining 34 were tested because of the presence of a handicap other than impaired hearing, e.g. speech defect, educational sub-normality, cerebral palsy, etc. The figure 34 does not, however, represent the total number of children with other handicaps who have been tested for acuity of hearing because many such are tested when they enter school in the routine groups.

Of all children under review in schools, whether first brought to light in 1962 or in earlier years, final assessments were made during 1962, as shown in Table II.

Table II — Final Assessments reached in 1962

	Routine	Special
No. found to have normal hearing	84	99
No. with residual loss due to:		
Recurring catarrh ... ..	22	19
Recurring wax ... ..	2	2
Otorrhoea ... ..	11	14
Unilateral nerve deafness ...	3	4
	38	39
		77

The degree of impairment of hearing in these 77 cases ("routine" and "special") discovered by audiometry and assessed in 1962 was as follows:—

Table III — Number of cases

	Severe	Moderate	Mild
Routine: Unilateral ... ..	2	8	14
Bilateral ... ..	—	3	11
Special: Unilateral ... ..	4	5	19
Bilateral ... ..	—	1	10

The criteria for degree of deafness were given in the report for 1961.

In the routine group the two cases with severe unilateral loss were both due to nerve deafness. The 8 cases of moderate unilateral loss had histories as follows:—nerve deafness following meningitis in infancy with right-sided hemiplegia as another sequel (1 case); otorrhoea despite

earlier operation (2 cases); and catarrhal conditions (5 cases), three of which had improved with treatment. The 14 mild cases of unilateral loss were mainly due to otorrhoea; they had all improved during the period between first discovery and firm assessment but still had a residual loss.

There were no cases of severe bilateral deafness as assessed in 1962. Of the 3 moderate bilateral cases, 2 were catarrhal with loss varying from time to time, while the third was due to otorrhoea and polypus of recent formation which may be improved by operation (in 1963). Eleven mild bilateral cases were of catarrhal origin, except for one in which there was a history of otorrhoea and another in which the cause was recurring wax.

In the special group the 4 severe unilateral cases were all of nerve deafness but no aetiological factor was found. The moderate cases were due to otorrhoea in 4 cases, the other presenting only catarrh. Fourteen of the mild cases were catarrhal in type and 5 gave a history of otorrhoea.

Again, as in the routine group, no special case came into the category of severe bilateral deafness. One moderate bilateral case was due to otorrhoea. The 10 mild bilateral cases were catarrhal in type in 6 instances, otorrhoeic in 2 and subject to recurring wax in 2.

The routine pure tone sweep test carried out for five years in the entrant age group in West Cumberland (school population 24,000) has brought to light over 200 cases of impaired hearing, including 4 severe and 50 moderate bilateral cases. A more complete picture is given in the table which follows:—

Table IV — Total assessment in routine and special groups for a five-year period

Year	Nos. tested		Degree of Impairment:—		
			Severe	Moderate	Mild
1958	3,645	Unilateral	7	4	8
		Bilateral	1	8	8
1959	4,891	Unilateral	7	13	17
		Bilateral	1	25	6
1960	2,995	Unilateral	3	9	11
		Bilateral	—	6	13
1961	2,836	Unilateral	4	8	10
		Bilateral	2	8	16
1962	2,451	Unilateral	6	13	33
		Bilateral	—	4	21
Total (1)		Unilateral	27	47	79
		Bilateral	4	51	64
Corrected Total (2)		Unilateral	25	45	73
		Bilateral	4	40	54

The correction is made in the second total to account for children who have left the district, etc. The figures in Table IV represent roughly the incidence in the total school population.

Seven new hearing aids were issued to school children during the year and one child started school already equipped. It is pleasing to note in passing that a grammar school boy with a hearing aid obtained passes in 9 subjects at the ordinary level."

Details of findings in pre-school children and an account of his work in the schools, are given in the report of Mr. M. Abbott, the peripatetic teacher of the deaf, as follows:



## “Pre-school Children

During the year one new case has come to light; this is a profoundly deaf boy who is now 21 months old and he has recently been issued with a Medresco transistor hearing aid. Three severely or profoundly deaf children were admitted to the Royal Cross School for the Deaf at Preston earlier in the year.

Two of the cases listed last year are now attending normal schools. They are progressing extremely satisfactorily and are integrating quite well into school life.

Parent guidance and pre-school training is being carried out at county clinics for the 3 children discovered in 1961 and the new patient mentioned above.

Co-operation from the parents is variable; an important factor is getting them to accept and admit to other people and themselves that they have a deaf child.

Early ascertainment is of great importance as the ‘oral’ way of life must be embarked on at an early age. All residual hearing must be used and backed up by training to use sight and tackle methods to understand speech and so enable the child to talk—particularly in cases of very seriously deaf children.

‘Gestures’ as opposed to ‘signs’ have a place in normal communication and are useful in the training of a child to give him clues, etc. However, habitual use has two dangers: it can cause a tendency to watch hands and not faces, and also a child can become reliant on it.

Formal signs have absolutely no place in the training of young deaf children and their use can be of real harm. Possibly these signs have a place with the so-called ‘oral failures’ at a much later stage of their education. However, one must first look for deeper reasons for these so-called oral failures, i.e. late discovery or perhaps an additional handicap.

Pre-school group:

Profoundly deaf	...	...	2
Severely deaf	...	...	1
Partially hearing	...	...	1
			—
			4
			—

The partially hearing child has an additional handicap.

### Pupils in Special Schools

The number of children from West Cumberland in residential schools for the deaf and partially hearing outside the county is 14. Three children have been admitted to the Royal Cross School for the Deaf at Preston in the last twelve months. In the same period 3 children have left residential schools and one boy has changed to a school for deaf children with an additional handicap.

### Children with Impaired Hearing in Normal Schools

Thirty-two children with impaired hearing are currently under supervision in normal schools in the area. Of these, 27 have transistor hearing aids, one being a commercial model, the remainder government-issued Medresco models. In comparison with 1961, 5 new children are under supervision, 6 have left school, 1 has left the county and 9 are no longer under the supervision of the teacher of the deaf as they have been consistently found to have a loss which was not significant educationally. These 9 children will have their hearing checked regularly by the audiometrician.

### Hearing Aids

Seven new hearing aids have been issued to school children during 1962, all being of the transistor air-conduction type. A point of interest here is that where initial issue is made at the primary school stage, usually little difficulty is encountered in getting the child to accept the aid. However, difficulty often, but not always, occurs with girls and to a lesser extent boys at the secondary education stage where there is often at least a cosmetic problem. Perhaps it may

be worthwhile to consider the issue of an aid at an early stage where there is a distinct possibility of it becoming necessary in the future.

The quality of fitting of ear moulds and the repair service offered by the hearing aid clinic at Carlisle is very high indeed. With the return postal service, peculiar to this area, no child should be without his or her aid for more than 48 hours.

Of the 32 children mentioned who are under supervision in ordinary school, the average loss on the main speech frequencies on the better ear is as follows:—

Up to 30 db. ... ..	11
30-40 db. ... ..	9
40-50 db. ... ..	11
50-60 db. ... ..	nil
Above 60 db. ... ..	1
	—
	32
	—

The above table does not give the complete picture. To take a particular case—Boy A—he has an average loss of only 35 db. on the better ear, but above 2,000 cycles per sec. the loss is of the nature of 85 db. on one ear and 95 db. on the other. This means in practice that the higher frequency sounds in speech such as 's,' 'sh,' 'ch,' 'th,' are heard imperfectly or not at all. Therefore, the boy concerned has to have regular speech correction and auditory training to help alleviate his particular problem. Unfortunately, several children suffer from this 'high frequency' loss and an added difficulty is that the hearing aid increases the volume of all frequencies to a degree. Almost half the children, particularly the younger ones, require constant help such as speech correction, auditory training, lip reading practice, and in some cases simple remedial teaching. The rest of the children are also under the supervision of the teacher of the deaf and are visited periodically. It has been found that apart from regular pure tone audiometry, speech audiometry

and checking of actual ability to reproduce speech sounds and combinations, that the testing of the child's reading age gives a very good indication of the success of normal schooling for a child with impaired hearing. Most of this tuition is given in the school to cut to a minimum the actual time lost in the classroom."

### **Defective Vision and Eye Conditions**

At each periodic medical inspection all children were given the usual test of vision, and each child on attaining the age of eight years (i.e. those born in 1954) had a further test.

Of the school entrants who numbered 3,260, 136 were referred for treatment and 375 were noted for further observation. In the eight-year-old group of children, 3,673 were examined and of these, 183 were referred for treatment and a further 337 for observation.

It will have been noted in an earlier part of the report that in the Southern area of the county, as from the beginning of the summer term, every effort will be made to ensure that every child has an annual vision test.

In last year's report, I mentioned that one of the school medical officers had commenced receiving instruction in ophthalmic work with Dr. Ross Wear. The scheme was not fully implemmented during 1962 owing to the appointment of Dr. T. P. Griffith, Consultant Ophthalmologist, to work in West Cumberland as from 1st October, 1962. It appears at the moment, however, that there is likely to be a further need for the help of at least one trained school medical officer in refraction work in West Cumberland, and arrangements are being discussed for a second school medical officer to receive training in this work.

### **Ascertainment and Treatment of Squint**

It is regrettable to have to report that orthontic clinics were only functioning during the first quarter of the year owing to the resignation of Miss Modlin on 1st April, 1962. Despite repeated advertisements, I was unable to appoint a



successor during 1962, but at the time of writing this report, Mrs. Richardson has been appointed on a sessional basis and is holding one clinic each week in Carlisle, starting on 6th February, 1963.

The waiting list of new cases at the end of the year does not include those children whose treatment had been suspended.

The following table shows the work carried out by Miss Modlin during the first three months of the year.

	Carlisle	Penrith	Workington	Whitehaven	Total
Total No. of attendances in 1962	95	55	89	98	337
No. of new cases seen	9	5	14	15	43
No. of new cases registered for treatment	3	1	5	5	14
Treatment during year of new cases:—					
Partially accommodative squint	—	1	—	1	2
Partially accommodative squint with amblyopia	2	—	1	2	5
Fully accommodative squint	1	—	1	—	2
Tonic convergent squint	—	—	—	1	1
Fixation disparity	—	—	1	—	1
Amblyopia	—	—	—	1	1
Divergence excess	—	—	2	—	2
	3	1	5	5	14
Discharges during year:—					
Cured	5	3	2	5	15
Cosmetic	2	1	3	5	11
Improved	—	—	1	5	6
Failed to attend	1	—	1	—	2
Left district	—	1	—	1	2
	8	5	7	16	36

### Orthopaedic and Postural Conditions

Three Consultant Orthopaedic Surgeons, Mr. McKechnie, Mr. Gordon and Miss Bucknell, are seconded by the Regional Hospital Board for sessional work in County



Council clinics. This extends to a figure of about 45 clinics in the year divided between the three consultants at Carlisle, Whitehaven and Workington, with less frequent clinics at Penrith. The County Council orthopaedic physiotherapists attend at these clinics with the surgeons and some idea of the volume and type of work dealt with is indicated in the tables shown below.

Number on aftercare register at 1.1.62	...	1,049
New cases during 1962	...	153
Cases referred for orthopaedic physiotherapist only	...	99
Cases re-notified after previous discharge	...	7
Cases attaining school age after having been referred originally from child welfare clinic	...	105
Number removed from register	...	281
Number on register at 31.12.62	...	1,132
Attendances at surgeons' clinics	...	704
Attendances at intermediate clinics	...	2,243
Homes visited by orthopaedic physiotherapists	...	414
Plasters applied	...	54
Surgical boots and appliances supplied and renewed (including insoles)	...	349
X-ray examinations during 1962	...	61

#### Conditions Affecting School Children

Flat feet	...	361
Bow legs and knock knees	...	273
Poliomyelitis	...	42
Scoliosis, lordosis and kyphosis	...	20
Congenital defects (including talipes and pes cavus)	...	130
Congenital dislocation of the hip	...	30
Torticollis	...	6
Injuries (including fractures)	...	9
Cerebral palsy	...	70
Postural defects	...	60
Hallux valgus and deformed toes	...	28

Birth injuries ... ..	9
Osteomyelitis ... ..	1
Perthes disease and coxa vara ... ..	17
Arthritis ... ..	2
Spina bifida ... ..	5
Synovitis and rheumatism ... ..	3
Schlatter's disease ... ..	3
Muscular dystrophy ... ..	4
T.B. joints ... ..	5
Paraplegia ... ..	2
Other conditions ... ..	52

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1,132

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Miss Morris, orthopaedic physiotherapist, writes as follows on the persistent problem of unsuitable footwear for school children:—

“ In dealing with school children and those under school age in the orthopaedic aftercare clinics, the problem of good footwear is constantly arising. Though we are presumably living in an age of plenty the provision of good and well fitting boots and shoes for children, and teenagers especially, is becoming increasingly difficult.

Starting with the small child who is under school age, and those up to about 10, good lace-up shoes can be bought without any difficulty and these are of a very good standard; but if boots are required, as with a marked knock knee, where a high inside wedge for correction is needed, or when a child has to wear an iron, the supply is very poor indeed, and particularly in those with a leather heel. These usually have to be ordered and are not available above size 12. The standard of shoes worn by the school child up to about 11 years is on the whole quite good, and we find the parents generally conscientious and anxious about their children's feet.

It is when the children, particularly girls, get into their teens (and often earlier) that our serious troubles start about

footwear. Some carry on with good school shoes until about 14 and then the quite genuine complaint from their parents is that they just cannot buy a lace-up school shoe in size 5 and 6. Unfortunately, this is often true.

We explain to these children and their parents the fact that at a stage when the joints of their feet can still be moulded, and can be distorted and deformed by bad shoes, they should be especially particular. We also argue that a plain lace-up type of shoe looks smarter and more correct with a school uniform. This does not appear to make much impression; unless parents and school authorities take a strong line the children will insist on following the fashion."

### **Speech Therapy**

The year 1962 was the first whole year during which there were three full-time speech therapists in post. This has not only had the excellent effect of bringing and keeping much of the work up to date, but also in bringing to discussion ways in which the work of the speech therapists might be extended further into the schools; it also led to further arrangements with the hospitals for sessional work there.

I am afraid, however, that at the time of writing this report one of the three speech therapists has resigned to take up another post, and, unhappily, a second has been involved in an accident which will set back the work in her area by a few months. I am hoping, however, that by the middle of 1963 last year's happy position will be restored.

Some progress has also been made during the year in establishing firmer lines of communication between the speech therapists and the school medical officers and specialist clinics—notably child guidance. I regard it of great importance that the school medical officer should be central in the picture when the various workers, educational psychologists, speech therapists and audiometricians are bringing their

skills to bear upon the school child. All cases being referred now for speech therapy are being considered by the school medical officer in the first place so that such matters as hearing impairment and psychological disturbance can be assessed, and the speech therapist be given as much guidance as is possible and necessary in each case. The speech therapists themselves are increasingly proving the value of a selective use of tape recorders in helping children to appreciate their own difficulties and learn to overcome them.

Three tape recorders are now in regular use and some of the tapes also provide a fascinating history of some of the cases treated.

During the course of the year the speech therapists used tape recordings to demonstrate to the Education Committee some aspects of their work, and it was generally felt that this was helpful and illuminating to members who were primarily responsible for providing this service in schools.

The work of speech therapy amongst sub-normal children has not been materially extended during the year. Time consuming and difficult of assessment as this work is, it has not seemed justifiable to deflect effort from the heavy demands on the service made by school children. Arrangements were completed towards the end of the year for all three therapists to give one session per week of their time to work in hospital, mainly with "stroke" cases. The intention that this time should be made up by the services of a part-time speech therapist had not actually been realised by the end of the year, but it is hoped that this will be established very soon.

The consultant services of Dr. Morley have continued to be most helpful to the three county speech therapists, and I am very sorry that Dr. Morley retires in 1963, though I hope that her successor will continue to visit Cumberland in an advisory capacity.

This year, Mrs. Blacklock gives an interesting account of her work as follows:—



“The speech therapy service in Cumberland has been run by three full-time therapists during the past year. This is the longest period with a full staff that we have had and it is noticeable that the service is benefitting from this. The waiting lists are being reduced at every clinic; indeed, in many the work is completely up to date. Better contact is being sought and maintained with other members of the school health service, and we are all able to spend more time in school visiting, though obviously the therapist has to give most of her time to diagnosis and treatment. When the waiting lists are reduced it does mean that we are able to see more pre-school children. The doctors may be confident that they are not overloading us with these young children who have seemingly unimportant speech defects. The earlier such a child is seen by the speech therapist the better; again and again we find that with careful management the primary stammering stage is outgrown and by the time the child comes to school age his speech is normal. Similarly, the child with defective articulation can be helped and even though his articulation may still be defective when he starts school he will probably be well adjusted to his difficulty. This early prophylactic treatment of young children with defective speech or language is of vital importance. The emotional and social adjustment of the family in general and of the child in particular can be attained; for where there is defective speech or language, one of the most important facets of the problem is the effect which the speech has on the speaker and on the listener. Parents always hope that their children will develop normally, and the emergence of defective speech can be very alarming. There are always the neighbours who know what to do for such conditions, and so often this advice is the very worst that can be given. To be told to “take no notice, he will grow out of it,” is indeed sound advice, but very difficult for a parent to apply unless guided regularly by someone who has plenty of time to discuss all aspects of taking no notice. Often it is said: ‘Oh, I take no notice of his speech, I just tell him to say the word over, or take a deep breath or start again, etc.’ It is so important



to make oneself clear and impress upon the parents exactly what is meant by ignoring the symptom but not ignoring the cause. The amount of guidance and treatment given to these parents and young patients varies a great deal from periodic interviews with parent and child, to treatment of the child each week, and guidance for the parent given either by the speech therapist or in some cases by a psychiatric social worker. A treatment programme is mapped out for each individual and needs constant adjustment as time progresses. It is indeed a blessing that for most people the development of normal speech and language is a relatively short, painless period, but for the few this development can be greatly delayed, for ever impaired and constantly a source of pain and embarrassment. Some patients need treatment for many years, but happily the majority only need help for a period of about two years. This includes actual treatment time and a period of review prior to discharge.

In Cumberland there are remote districts where transport is inadequate and visits to a clinic may mean a whole day missed from school. In these cases one has to weigh very carefully the merits of half an hour of treatment against missing one-fifth of a week's schooling for a period of maybe twelve months. That is why it is so good to be able to reduce waiting lists and then to be able to spare the time to go to these rural schools to treat these children with a minimal loss of their school time. In Workington, however, it has still not been possible to reduce the waiting list as much as had been hoped. Further sessions will be necessary at this centre to deal with the case load.

Since May, 1962, a speech therapy service has been initiated at the Cumberland Infirmary to work primarily in conjunction with the plastic surgery clinic in the review of all cleft palate patients. The majority of these patients are either pre-school or school children. Every cleft palate patient is seen each time he attends the hospital out-patient department, by the consultant plastic surgeon and the speech therapist. The therapist makes an assessment of the patient's

speech and then if speech therapy is indicated this is arranged either at the hospital or in one of the county clinics. This co-operation ensures the best possible treatment and supervision of each case, and applies to those patients who go to Newcastle for surgery by Mr. Braithwaite.

From the detailed analysis of the types of defects found within the group of speech defective school children, it will be seen that stammering is responsible for attendance by a high percentage. If this number were broken down still further it would be clear that most of the eight- to ten-year-olds attending do so because of a stammer, and nearly all twelve- to eighteen-year-olds who attend the speech clinics have a stammer. Of these numbers, boys far outnumber girls. Treatment for a stammer can be beneficial at any age, but there are some patients who do not benefit from treatment. These are few in number and more often have the additional handicap of low intelligence. Frequently, children between the age of eighteen months to four years go through a stage in speech development where they lack fluency and may repeat either the whole word or the initial sound of a word. This repetition is easy flowing with no increase of tension and is readily outgrown. However, if attention is drawn to this symptom it may become established and develop into a true stammer; but these patients can be helped and age is no drawback to success. With children below eight years of age treatment is almost entirely indirect and aims to encourage free speech and growth in confidence, mainly through play situations either individually or in small groups, together with parent guidance. From eight years of age onwards children can co-operate more fully and are taken either in groups or individually. The eleven-year-old patients are passing through a very upsetting period, including the selection examination and a change of school. I have found that these children are helped at this stage by gaining a good deal of insight into their problems. The young adolescents are probably the very best material as far as therapeutic procedure is concerned. The incentive at this age for improving one's speech is strong. Individual

treatment seems best suited to this age group and also to the adults.

There does seem to be a tendency to inherit the syndrome which includes eczema, asthma and stammering. Within this group of 50 stammerers in East Cumberland—7 of whom are girls—29 have a family history of stammering, 13 a history of asthma, 4 of eczema, and 4 of the children themselves have asthma and eczema in addition to their stammer. Where, as with functional defects of articulation, the aim is to produce normal speech, with a stammer a complete cure is never claimed because however good the adjustment to the stammer and the reduction in the symptom future unforeseen periods of stress may precipitate the stammer again.”

The following table shows details of cases treated and attendances during the year:—

				North Cumberland	West Cumberland	South Cumberland	Total
On register 1.1.62	...	...	...	115	123	158	396
Admitted ...	...	...	...	49	83	71	203
Discharged	...	...	...	27	76	62	165
On register 31.12.62	...	...	...	137	130	167	434
Waiting list (included on line above)	...	...	...	6	2	—	8
Particulars of cases dis- charged:—							
Normal	...	...	...	15	45	45	105
Improved, unlikely to benefit further	...	...	...	3	9	8	20
Lack of co-operation	...	...	...	1	10	6	17
Left school and/or district	...	...	...	8	10	3	21
Passed to teacher of deaf	...	...	...	—	2	—	2
				27	76	62	165
Cases treated:—							
Dyslalia	...	...	...	50	87	10	147
Stammer	...	...	...	33	66	43	142
Stammer and dyslalia	...	...	...	7	3	4	14
Sigmatism	...	...	...	—	—	4	4
Cleft Palate	...	...	...	11	13	13	37

Hard of hearing ... ..	2	2	—	4
Dysarthria ... ..	—	4	2	6
Dysphonia ... ..	—	1	—	1
Dysphasia ... ..	—	2	—	2
Retarded speech development...	14	43	123	180
Dyslalia and dysphonia ...	—	—	1	1
Dyslalia plus low intelligence ...	—	—	15	15
Developmental dysphasia ...	—	—	4	4
Lateral sigmatism ... ..	1	10	—	11
Stammer and lateral sigmatism...	—	—	4	4
Dyspraxia ... ..	3	7	—	10
Dyslexia ... ..	—	—	5	5
Submucous cleft ... ..	1	1	1	3
Hyponasality ... ..	1	—	—	1
	123	239	229	591

Attendances:--

	Attendances	Waiting List
Cleator Moor ... ..	274	—
Egremont ... ..	208	—
Ingwell ... ..	57	—
Millom area ... ..	455	—
Seascale ... ..	85	—
Whitehaven ... ..	710	—
Cockermouth ... ..	226	—
Keswick ... ..	108	—
Penrith ... ..	416	—
Workington ... ..	535	—
Aspatria ... ..	165	—
Carlisle ... ..	613	6
Maryport ... ..	384	2
Wigton ... ..	172	—
Wiggonby School ... ..	18	—
Plumbland School ... ..	43	—
	4,568	8



### Child Guidance

Since the beginning of the year, Mr. Mayoh, Senior Mental Welfare Officer and Psychiatric Social Worker, has been fully integrated into the East Cumberland team and he comments as follows on his work on the place of the psychiatric social worker:—

“ The Psychiatric Social Worker commenced his duties in the East Cumberland Child Guidance Clinic on the 1st March, 1962, and during the year made 61 home visits.

The P.S.W. works with the Consultant Psychiatrist and the Educational Psychologist as part of the Child Guidance Team. His function includes the initial interview of parents in the home, the compilation of social histories, on occasions casework with the parent and/or child, and the visiting of selected families after the formal discharge of the child from the clinic. He takes part in the full discussion of cases.

The P.S.W. is responsible, under the Psychiatrist, for the routine administration of the Child Guidance Clinic and the keeping of case records.

Of the 25 children referred during 1962 to the clinic, the cause of the disturbance could be seen to have some connection with the home circumstances of the child, and in particular to the relationship between the child and his parent(s) in 14 cases, and in 2 of these 14 difficulties at school were a contributory factor. So far as the remaining 11 children are concerned, the causes of the symptoms were less easily discoverable.”

The arrangement in West Cumberland with Dr. Ferguson for selected school nurses to undertake as much as possible of the work of a psychiatric social worker has proved successful, and Dr. Ferguson has found their assessments of the home situations very valuable. Mr. Mayoh has kept in touch with the two nurses concerned, and advised them as to the type of reports required.



A meeting was held in January with the Director of Education, Dr. Gibson and Dr. Platt regarding the possibility of Dr. Gibson establishing a hospital child psychiatric clinic in West Cumberland, and such a clinic started at the beginning of February in Flatt Walks Clinic, Whitehaven. The number of referrals to this clinic have not been large but this is understandable because it was never intended that the clinic should take the place of the school health service child guidance clinic. At the end of the year, Dr. Gibson stated that he had seen 30 children since the clinic started. It is interesting to note that this figure is about 15% of the total child guidance cases referred in West Cumberland during 1962.

I am grateful to Dr. Ferguson for the following interesting account of the work of his clinic during 1962:—

“Attendances and referrals have remained much as in previous years. A significant feature, however, over previous years is the prolonged psychotherapy which has been undertaken at the West Cumberland clinics of Workington and Whitehaven. We have had a number of interesting cases at these clinics which have responded to such treatment. Of particular interest was a small boy of six years, referred in the last weeks of 1961 by the speech therapist. At that time he stammered badly, bit his nails, pulled his hair out, chewed and plucked blankets, bit his clothes. He was also blind in one eye, as well as being physically very small. Intellectually he was average. Associated with these difficulties were difficulties of reading and writing. He read from right to left, wrote in the same way, though usually upside down.

Play therapy and remedial teaching were undertaken and he was seen weekly for nine months. During this time all his symptoms left him, he became able to use the normal left-right orientation and he gained in assertiveness and self-esteem. On review six months later, his mother's only comment was that he was now a bit of a bully as far as

his younger and physically average brother of five years was concerned.

We have become increasingly aware of some of the emotional difficulties underlying adoption and have had to give advice and in some cases active help. We are finding that sometimes the feelings and attitudes of parents of adopted children have changed when a natural child has come along, and these parents often need help to re-examine their motives in adoption and to accept the changed situation. Maladjustment in adoption can be an important causative factor in delinquency and the Child Guidance team is able to make a major contribution in preventing a progression to more serious behaviour problems.

Child Guidance work generally has the twin objectives of helping the child to cope with his feelings and attitudes to the adult world, and secondly to exert such influences as are necessary to promote the development of a good citizen. In this connection, we do not see a child or his family in isolation from the wider culture in which we all live. We are aware, for instance, of the effect the prevailing economic trends in the area have on many families, and indeed on the social life of the entire area.

We have had cordial relations with the Probation Services in the area, and often see children before their court appearances. In some cases, attendance at the Child Guidance Clinic has been made a condition of their probation order, and we have been able to deal with aspects of the child's behaviour beyond those normally dealt with by probation officers.

We are still without professional social workers, which puts a strain on team members. At the same time, the district nurses/health visitors seconded to the team have made a useful contribution to our efforts."

The following table shows details of the work carried out at the Child Guidance Clinics:—

# CHILD GUIDANCE CENTRES—STATISTICAL RETURN FOR THE YEAR ENDED 31.12.62

## STAFF:

	Carlisle	Maryport	Whitehaven	Millom	Total
Psychiatrist ... ..	Dr. Stuart	Dr. Ferguson	Dr. Ferguson	Dr. Ferguson	
Educational Psychologist ... ..	Dr. H. Blair Hood	Dr. H. Blair Hood	Mr. K. G. Hare	Mr. K. G. Hare	
Psychiatric Social Worker ... ..	Mr. L. Mayoh				
Cases remaining on register at January 1st, 1962 ... ..	46	16	150	18	230
New cases referred during year by:—					
Consultants or General Practitioners ...	13	7	60	2	82
School Medical Officers ... ..	6	3	40	2	51
Children's Officer ... ..	2	—	—	—	2
Parents ... ..	—	—	—	—	—
Schools ... ..	4	3	30	—	37
Probation Officers or Courts ... ..	—	—	20	—	20
Others ... ..	—	—	—	—	—
Cases re-opened during year ... ..	3	—	—	—	3

Total cases on registers during year ...	74	29	300	22	425
Cases dealt with and closed ... ..	47	14	60	3	124
Cases remaining under treatment at 31.12.62 ... ..	26	15	240	19	300
Cases awaiting treatment at 31.12.62 ...	1	—	—	—	1
Interviews by Psychiatrists ... ..	74	29	300	22	425
Interviews by Social Workers ... ..	270	93	225	60	—
Interviews by Educational Psychologist ...	79	—	—	—	(no social worker)
	111	111	165	60	—

## HANDICAPPED PUPILS

In my Annual Report for 1961 it was particularly appropriate to comment on the handicapped child's problems on leaving school, since a scheme had been introduced for the follow-up of educationally subnormal leavers in succession to the old "Section 57(5)" examination, eliminated by the Mental Health Act, 1959; and also the assumption of welfare responsibilities had brought about a new approach to the physically handicapped school leaver as a potentially handicapped adult. Administrative thinking in 1962, however, has centred rather on the pre-school child with a potentially handicapping condition.

Although the Education Act, 1944 recognises an education authority's responsibility to "ascertain" all those children in the area from the age of two years who are thought to be suffering from a handicapping condition, it has become increasingly clear in recent years that it is a matter of some urgency that potentially handicapping conditions should be anticipated if at all possible at birth. We are faced today with a concept of maturation and learning processes which speaks in terms of "critical periods" for the development of different physical and psychological functions. It seems probable that when the "critical period" for the development of a certain function, e.g. speech, has passed, a child's learning process in this direction is a much more difficult journey possibly beset by concomitant emotional, behavioural complications. Hence the great importance of the earliest possible detection of hearing impairment in a young child which led to the establishment of the arrangements in the county, reported in my Annual Report for 1961, for all children to have a screening test of hearing at 9 to 12 months. The broad view of this field of developmental research and thought has given rise to the concept of an "At Risk" register being established by local health authorities containing the names of all children who, because of some known factor of abnormality at, or soon after birth or a significant family history, are known to be



at greater risk of developing a serious physical or mental defect than the child population in general.

It does not require to be emphasised that these children are the school children of a very few years from now and so this type of register, now established in this health department, has a very real relevance to the school health service as it relates particularly to handicapped children. Arrangements have been made to ensure as far as is possible that all "At Risk" children are kept under special supervision until it is established whether any anticipated condition is developing or not. Previous arrangements linking the child welfare section and school health section, both administratively and through field staff, had already ensured that most handicapped or potentially handicapped children reach school entry well known to, and usually assessed by, the school medical officer; the "At Risk" register will, it is hoped, ensure that many of these children are in fact detected and brought under treatment earlier than previously and so reach infant school better equipped for a successful, if in some cases somewhat "special," school career.

### **Blind and Partially Sighted Pupils**

There are 7 blind children and 5 partially sighted children in special residential schools outside the county.

We are fortunate in Cumberland in having little difficulty in finding places in special schools for partially sighted children. The Minister of Education has recently been enquiring into the factors affecting the demand for places in these schools, with special regard to the increased use of modern low-visual-acuity aids and the imprecise borderline between partial sight and blindness on the one hand, and reasonably normal vision on the other. Altogether, there are 17 ascertained partially sighted children in the county, and during 1962 two of these were issued with illuminated desk magnifiers which have proved very beneficial in enabling them to cope in ordinary school. It is also interesting to note that 5 of these 17 children have other handicaps, in 4 cases handicaps of greater severity than their visual defects; indeed, one little girl is a pupil in a special school for the deaf.



During the year 5 young people left school, 2 leaving ordinary school, 2 a special school for the blind, and one a school for the partially sighted. One blind young man is now employed by the County Council as an audio-typist following training in this work at the Royal Normal College for the Blind; both the other boys are, I am pleased to be able to report, in regular employment. Unfortunately, neither of the boys who left ordinary school are working; one has, however, been on an industrial rehabilitation course and has prospects of employment in the spring of 1963.

Recently, the Royal National Institute for the Blind has issued a memorandum on the "Care of Young Blind Children," pointing out the services of a residential unit where parents stay with their blind children for a few days, and indicating that they can arrange for their specialist advisers to visit blind children in their own homes, when help is needed to supplement that of the home teachers and health visitors. Also mentioned was the value of parents' meetings, and these are now being considered in Cumberland. Geographically, the parents of blind children are very scattered in Cumberland, and it will probably only be possible to arrange meetings of two or three parents in any locality.

### **Deaf and Partially Hearing Pupils**

There are at present 33 school children known to be handicapped by deafness or partial hearing. In September, Circular 10/62 was issued by the Ministry of Education, introducing the term "partially hearing" in place of "partially deaf." This new definition is the result of recent developments in the education of children with impaired hearing, and reflects a more positive approach to the use of residual hearing, and the importance of early diagnosis. Now, with the appointment of a further audiometrician, all school entrants will have their hearing tested during their first year at school; and, of course, special attention is paid to babies attending child welfare clinics, particularly those "At Risk" or handicapped, as is reported earlier in the

audiology report. The Minister also recommends the establishment of special classes in schools for the possibly deaf and partially hearing—an expedient which does not seem practicable in this type of rural authority. When two full-time peripatetic teachers are operating, guidance will be available for all children in their own schools, not only in helping the children, but in advising their class teachers, and in securing the co-operation of schools and parents in the training of the children.

Towards the end of the year a demonstration of a new model of speech audiometer was arranged, and although speech audiometry will continue to be a valuable addition for the teachers of the deaf, it was decided that under present conditions the pure tone sweep test was more appropriate for school entrant screening.

During the year two boys left special residential schools, one for the deaf, and one for the partially hearing—neither is employed at the time of writing, one because of the severity of his handicap, and the other because of the present employment situation in West Cumberland.

Most important in this connection is the pioneering work being carried out at the Keswick Youth Centre under the guidance of Mr. C. Wilson, Education Department, and Mr. Hayhurst, Carlisle Diocesan Association for the Deaf, where many outdoor activities, including rock climbing, have been brought within the reach of the deaf. At a conference which I attended during the year of the Institute for the Deaf in London, Mrs. Sheavyn, Youth Officer to the Institute, commenced a most impressive speech by describing the work done at the Keswick Youth Centre, stressing the need of activities with a spice of danger for deaf young people.

### **Children suffering from Epilepsy**

There are 31 school children suffering from epilepsy, 3 of whom are at special residential schools. While most epileptics can be educated quite satisfactorily in ordinary

schools, one particularly difficult case seems to come forward each year. In 1962 this was a girl of 12 years who was finally excluded from ordinary school after a series of events, and in view of the problem of keeping her under the constant supervision she required. There was a difficult home background but finally parental consent was given and she was admitted to a residential special school. Her first months at the school were particularly troublesome as her epilepsy is complicated by a serious psychological disturbance. However, the school authorities have been extremely patient with her, and following an examination by a consultant psychiatrist recently, I am very pleased to say that she seems to be settling down better on new treatment.

During the year one boy left special school and is at present awaiting admission to an epileptic colony, and another boy who was withdrawn following ascertainment as "unsuitable for education" in school, and is now attending the Whitehaven Training Centre.

### **Educationally Subnormal Pupils**

The statistics of 2 H.P. examinations completed in 1962 and the waiting list for Ingwell and Higham Schools are shown below. During the year there was a disturbingly large number of failures to keep appointments for 2 H.P. examinations, over 40 in fact, and in many cases with no warning or explanation being given. This resulted in a waste of much valuable time by school medical officers, and a large waiting list at the end of the year. Discussions with the Director of Education led to a new appointment letter stressing the importance of keeping the appointment, and it is to be hoped that this will bring a better first-time attendance record.

Owing to the inadequate provision of places in special schools in the county, most children who have been ascertained educationally subnormal are educated in progress classes. At the end of the year 20 of the 24 non-selective secondary schools had these classes and there were a further

12 in junior schools. These numbers tend to fluctuate, depending on the availability of a suitable teacher and pupils, though in some schools they are firmly established. Nevertheless, of the 49 educationally subnormal children recommended this year (62 in 1961) for education in special schools, only about 15 will receive this type of education. I hope that priority will be given to the building of extensions at Ingwell and Higham Schools to provide an extra 12 places in each school, in order to relieve the position to some extent.

In my report for 1961 I gave details of arrangements for the supervision of educationally subnormal school leavers. This procedure worked very satisfactorily during the year and of the 68 educationally subnormal children who left school in 1962, 40 (59%) were placed under supervision, 32 by health visitors, and 8 by mental welfare officers. Of the 8 under mental welfare officer supervision, usually the more difficult cases because of delinquent tendencies or very limited intelligence, 3 are in regular employment and have caused no trouble; in fact, I understand one young man, having failed to find employment, has set up successfully as a newspaper vendor and is continuing to expand his business! Of the remainder, 2 can be considered unemployable; one of these is awaiting admission to an epileptic colony. The position regarding those placed under health visitor supervision is considerably better than I anticipated, considering the employment situation in West Cumberland. 20 (63%) are in regular employment. Of the 12 unemployed, 6 cases can be attributed to the unemployment situation, and 3 can be said to be unemployable, e.g. one boy is under treatment for mental disorder, and a girl is a severe epileptic. The remaining three are the unsatisfactory cases, two having lost their jobs because they were inadequate or too immature.



## 2. H.P. EXAMINATIONS COMPLETED IN 1962

### UNDER SECTION 34 or 57

Recommended Special School—E.S.N. ...	49
Recommended Special Class—E.S.N. ...	34
Reported unsuitable for education at school ...	18
No special educational treatment required ...	18
Decision deferred ...	10
<hr/>	
Total ...	129 (128)
<hr/>	

Number of Boys on Waiting List for Ingwell School ...	81
Number of Girls on Waiting List for Higham School ...	53
<hr/>	
Total ...	134 (127)
<hr/>	

### NEW CASES REFERRED IN 1962

Placed under supervision for further investigation  
of intellectual capacity.

Referred by:--

School Medical Officers ...	14
Psychologists and Teachers ...	49
Consultants and Hospitals ...	5
Health Visitors ...	11
Others ...	4
<hr/>	
Total ...	83 (181)
<hr/>	



The figures shown in brackets against each total are the corresponding figures for 1961. The number of 2 H.P. examinations remains fairly constant, but there has been a considerable drop in the number of new cases referred by teachers and psychologists. It is true, of course, that an increased number of children are coming under supervision from this point of view before school entry, and so do not show as referrals by psychologists or teachers. At the beginning of the year we welcomed Mr. K. G. Hare as the Educational Psychologist in West Cumberland in place of Miss M. Grey.

The panel which selects those children to be offered a place in Higham or Ingwell School meets four times in a year and gives detailed consideration to the relative merits of the various children recommended for such placement. The task is difficult, however, in view of the large number of candidates for each vacancy. By general agreement several years ago the age range for admission to Ingwell School is taken as 10-12 years, and for Higham 9-12 years, while as a general rule an I.Q. of 60-75 is used as a general guide as to the level of ability most suitable for these schools. Inevitably one result of selection on this general basis is that a substantial number of children of even lesser ability than this must remain in ordinary schools, with or without a progress class. The selection panel consists of the Assistant Director of Education, the Deputy Principal School Medical Officer, and both Educational Psychologists, who have before them the full records of each child and the opinions of school medical officers, head teachers and any others concerned in the child's educational ability.

### **Physically Handicapped Pupils**

This is by far the largest group of handicapped children, other than the educationally subnormal. At the end of the year there were 150 children ascertained as physically handicapped, and this section is broken down into four main categories: Spastic, Orthopaedic, Heart Conditions and Respiratory Diseases. There are, of course, some conditions

which cannot be classified under these categories, e.g. dwarfism, hydrocephalus and nephritic diseases or abnormalities.

Spastics are the largest group numbering 46 or 31% of those ascertained, i.e. for whom a Form 4 H.P. has been completed by a school medical officer. The Form 4 H.P. records details of the handicap, and on it recommendations are made for any special educational treatment. In some cases a special school is necessary; in others, some form of limitation on ordinary school activities, e.g. games and physical education; or special transport may be required to take the child to and from school. Sometimes a special provision has to be made for the child, such as a larger desk or a wheelchair in school. In many cases no immediate action need be taken at all; for example, there are 21 children with heart conditions, most of which are congenital in origin, and the Form 4 H.P. is completed to record the defect and ensure that the child is examined annually at the school medical inspections, so that any change in the condition can be acted upon. Particular care is given to the recording of the appropriate handicaps as "Dental Risks."

There are 32 children with orthopaedic conditions varying from old poliomyelitis cases to osteomyelitis and spina bifida, and 18 with respiratory diseases.

### Children Suffering from Cerebral Palsy

The numbers in this category at 31st December, 1962, are as follows:—

Number of spastic children of school age—

West Cumberland ...	...	...	...	...	47
East Cumberland ...	...	...	...	...	15
					<hr/>
Total ...					62
					<hr/>

These may be divided into those:—

(a) Attending ordinary school ... ..	30
(b) At Percy Hedley School for Spastics (Newcastle) ... ..	6
(c) At residential schools for the physically handicapped ... ..	3
(d) At residential schools for the educationally subnormal ... ..	1
(e) Attending Training Centre ... ..	3
(f) At Dovenby Hospital ... ..	5
(g) At Prudhoe Hospital ... ..	1
(h) Having home tuition ... ..	3
(i) Not attending school, not having home tuition ... ..	10

In addition:—

Number of children under school age but within the scope of the Education Act, 1944 (i.e. 2-5 years) who are known spastics—

West Cumberland ... ..	12
East Cumberland ... ..	6
Total ... ..	18

**Table Showing Handicapped Children in Special Schools**  
**BLIND**

Name of School	Boys	Girls
Royal Victoria School for the Blind, Newcastle	4	2
Worcester College ... ..	1	—
Total ... ..	5	2

### PARTIALLY SIGHTED

Preston School for Partially Sighted and Institute for Blind Welfare, Fulwood	...	...	2	—
Exhall Grange School, Warwickshire	...	...	1	1
Barclay School for Partially Sighted Girls, Berkshire	...	...	—	1
Total			3	2

### DEAF

Northern Counties School for the Deaf, New- castle	...	...	...	...	...	1	1
St. John's, Boston Spa	...	...	...	...	...	1	3
Royal Cross School for the Deaf, Preston	...	...	...	...	...	—	2
Royal Residential Schools for the Deaf, Man- chester	...	...	...	...	...	—	2
Thomasson Memorial School, Bolton	...	...	...	...	...	—	1
Bridge House School, Yorkshire	...	...	...	...	...	1	—
Total			...	...	...	3	9

### PARTIALLY HEARING

Name of School	Boys	Girls
Liverpool School for the Partially Deaf, South- port ... ..	1	3
Northern Counties School for the Deaf, New- castle ... ..	1	—
St. John's, Boston Spa ... ..	—	1
Royal Cross School for the Deaf, Preston ...	—	1
Total ...	2	5

## EDUCATIONALLY SUBNORMAL

Ingwell School, Moor Row	...	...	...	49	—
Higham School, Bassenthwaite Lake	...	...	...	—	34
York Day School, Carlisle	...	...	...	2	—
Eden Grove School, Bolton, Appleby	...	...	...	1	—
Dinsdale Park, Darlington	...	...	...	1	—
Total				53	34

## EPILEPTIC

Colthurst House School for Epileptics, Warford, Cheshire	...	...	...	...	2	—
Sedgwick House, Kendal	...	...	...	...	—	1
					<hr/>	
Total					2	1

## DELICATE

Name of School	Boys	Girls
Children's Convalescent Home, Cheshire	...	—
St. George's Hostel, Kersal, Manchester	...	1
Total		1

## PHYSICALLY HANDICAPPED

Hesley Hall School for Physically Handicapped, Tickhill, Notts.	...	...	...	...	1	—
Percy Hedley School for Spastic Children, New- castle	...	...	...	...	3	3
Irton Hall School, Holmrook	...	...	...	...	2	1
Exhall Grange School, Warwickshire	...	...	...	...	1	—
Bleasdale House Residential School, Silverdale, Lancashire	...	...	...	...	1	—
Lord Mayor Treloar College, Froyle, Alton, Hants.	...	...	...	...	1	—
Coltness House School, Wishaw, Lanarkshire	...	...	...	...	1	—
Total					10	4



## Dental Service

Mr. Neal, the Principal School Dental Officer, makes the following comments on the dental service:—

“ This report is being written at a time when there is great hope that in the comparatively near future preventative dentistry will be a matter of major importance and there is every prospect of the incidence of dental caries being reduced by up to 60% over the next eight years or so.

Fluoridation is the greatest advance in dentistry of all time and, now that there is Government support for fluoridation schemes, it is to be hoped that Cumberland will continue to lead in progressive policy and adopt universal fluoridation of its water supplies. Personal prejudice by certain individuals will be the only real stumbling block. Therefore, in order to show the people just what advantages they would be withholding from the children, the dental health education programme will have to be extended considerably and the benefits of fluoridation of water made known.

The dental department now has a full complement of both officers and surgery assistants and complete dental treatment can be offered to every child attending school in Cumberland. In order to enable the dental officers to provide a really comprehensive service a full course in orthodontics has been arranged for every dental officer. The course starts in January, 1963, and this will reduce considerably the number of visits made by patients to the consultant orthodontist at the City General Hospital or the Workington Infirmary. This will make it unnecessary for parents to take either half or a full day off work to accompany the child and will be particularly appreciated by the people who live in remote districts and, in particular, the Millom area.

In recent years the need and demand for orthodontic treatment has increased enormously and present facts show that 47% of all children require orthodontic treatment in

some form—whether by serial extractions, appliance therapy or a combination of both. The vast majority of orthodontic treatment will in future be undertaken in the county clinics, but under the supervision of the consultant orthodontist. This new policy will be to the advantage of everyone, particularly the patients.

Modernisation of clinics will be commencing during the coming year and will provide much greater comfort for the patients. It will most definitely enable the dental officers to work in more congenial surroundings, which, together with more up to date equipment, will permit of a greater volume of work being done with less fatigue.

It is most encouraging to note that the ratio of extractions to fillings is still decreasing, thus proving that more conservative work is being done. Now that there is complete coverage of the county the necessity for extractions, except for orthodontic reasons, is becoming less and the general standard of dental health increasing.”

## PREVENTION OF INFECTION

### *Protection against Tuberculosis*

All children reaching the age of 13 during 1962 have again been offered protection against tuberculosis in the form of a skin test and, where necessary, B.C.G. vaccination. Pupils reaching the age of 15 have been given the opportunity of having a mass miniature X-ray.

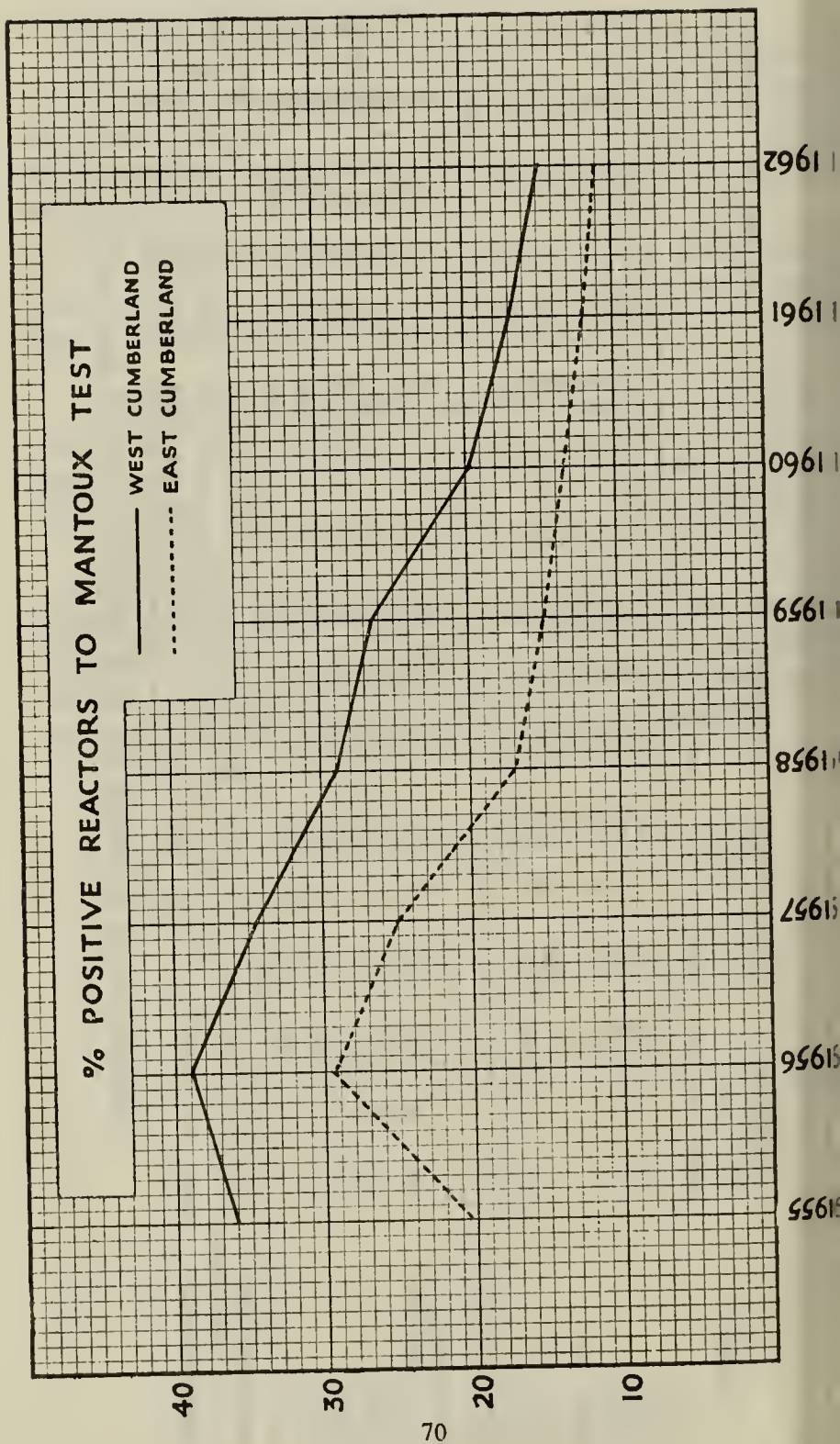
The following table shows the work carried out in connection with the Mantoux and B.C.G. schemes in 1962, with comparable figures for the previous two years:—

Year	No. offered		% of	No.		% tested	No.	% found	No.
	Mantoux	No. of		Mantoux	Tested		found		
	Test	consents	consents			of those	positive	positive	B.C.G.
						offered			
1962	3,766	2,968	79	2,663	71	356	13.3	2,206	
1961	3,854	2,909	75	2,671	69	405	15.2	2,185	
1960	3,423	2,560	75	2,406	70	419	17.4	1,925	

The following table shows the number of 13 year old school children Mantoux tested and found positive during 1962 with figures for the previous five years shown for comparison. The graph illustrates quite clearly the gradual fall in positive reactors, both in East and West Cumberland.

DISTRICT	Children born 1948			Children born 1947			Children born 1946			Children born 1945			Children born 1944			Children born 1943		
	No.	Pos.	%	No.	Pos.	%	No.	Pos.	%	No.	Pos.	%	No.	Pos.	%	No.	Pos.	%
Alston	26	4	15.4	22	2	9.1	36	5	14.0	27	10	37.0	39	6	15.4	32	19	59.4
Border	354	33	9.3	369	53	8.9	265	35	13.2	237	31	13.1	267	38	12.8	230	49	21.8
Keswick	79	11	14.0	118	29	24.6	83	19	22.9	78	17	21.8	92	19	20.7	99	28	28.3
Penrith R.D.	*	*	*	*	*	*	43	7	16.3	69	8	11.6	66	16	24.2	62	10	16.1
Penrith U.D.	230	27	11.7	233	32	13.7	176	25	14.2	143	23	16.1	135	20	14.8	134	30	22.4
Wigton	245	28	11.4	274	28	10.2	231	20	8.7	278	39	14.0	288	52	18.1	283	69	25.3
<b>Total East Cumb.</b>	934	103	11.0	1016	124	12.2	834	111	13.3	832	128	15.4	887	151	17.0	840	205	24.4
Cockermouth R.D.	9	1	11.1	23	3	13.0	25	1	4.0	25	7	28.0	14	3	21.4	60	18	30.0
Cockermouth U.D.	198	30	15.2	194	50	25.8	188	46	24.5	140	33	23.6	157	34	21.7	104	30	28.8
Ennerdale	315	58	15.3	323	69	21.3	251	66	26.3	234	80	34.2	286	101	35.3	311	114	36.7
Maryport	136	16	11.8	97	11	11.3	126	23	18.3	137	29	21.2	160	50	31.3	108	41	38.0
Millom	134	12	9.0	155	17	12.6	170	28	16.5	176	56	31.8	184	64	34.8	170	60	35.3
Whitehaven	414	79	19.1	437	89	20.4	428	91	21.3	297	88	29.6	384	129	33.3	325	111	34.1
Workington	525	57	10.9	446	42	9.4	384	53	13.8	374	69	18.4	400	82	20.5	358	118	30.2
<b>Total West Cumb.</b>	1731	253	14.6	1655	281	17.0	1572	308	19.6	1383	362	26.2	1585	463	29.2	1436	492	34.3
<b>GRAND TOTAL</b>	2665	356	13.3	2671	405	15.2	2406	419	17.4	2215	490	22.1	2472	614	24.8	2276	697	30.6

\* Children living in the Penrith R.D. have moved into schools in the Penrith U.D.





The pilot Mantoux Survey of groups of 100 school entrant children in four areas of Cumberland which was mentioned in last year's report was completed at the end of March, 1962. The survey was disappointing in that it was not possible to Mantoux test a sufficient proportion of those children approached, to give the results statistical validity. The general indication was, however, that the reactor rate was considerably less than in the 1954 survey.

### *Protection against Diphtheria and Tetanus*

The immunisation programme in schools has continued during the year as previously, and the offer of a primary course of tetanus at the same time as the diphtheria reinforcement injection continues to be well accepted by parents. It is being found that, in the larger towns of the county, only one reinforcement injection of diphtheria tetanus is required in order to bring most school entrant children's immunisation state up to date. This is because, as an infant, the child has received a course of "triple" injections, protecting him against diphtheria, whooping cough and tetanus. For the remaining children three injections are necessary, but the time will come, say in two or three years, when only one reinforcement injection will be necessary for the large majority, because "triple" injections in infancy have now almost completely replaced the single antigens. Obviously, of course, this is entirely dependent on a very high level of infant and pre-school protection being achieved and maintained.

In many of the smaller county schools the first of the three reinforcing injections is now given at the annual school medical inspection, the other visits being made at 4 - 6 weekly intervals. These last two visits do take up a good proportion of a medical officer's time, but this has been cut down to a minimum by the use of disposable syringes for all injections in schools. The use of these disposable syringes has two distinct advantages. The first is that, being completely sterile, there is no risk of any cross infection; and second, because of time saved, it is often possible for a medical officer to visit up to eight smaller schools in one day.

In spite of two vacancies on the medical staff during the last quarter of the year, the numbers of school children immunised against diphtheria during the year were as follows:

Primary course	...	...	540
Reinforcing injection	...	...	3344

This, compared with 394 primaries and 987 boosters given during 1961, is a welcome increase. It is estimated that, at the end of the year, the immunity index of school children, i.e. the percentage of children who have received a primary course or a reinforcing injection at any time during the past five years was 44.0%. The index at the end of 1961 was 44.6%. This index is not regarded as satisfactory and every effort is being made to improve it. In July a circular was received from the Ministry of Health drawing attention to the varying immunity index returns throughout the country and requesting local health authorities to draw up a comprehensive plan to maintain as high a level of vaccination and immunisation as possible in their areas. As a result of discussions held as to the best means of improving the immunity index in Cumberland it was decided to employ a part time medical officer temporarily in West Cumberland to bring forward this work in schools.

4,321 school children received a primary course of tetanus injections during the year and 1,096 received boosters to reinforce previous ones. I mentioned in last year's report that a system had been started of notifying the hospitals of all children receiving tetanus injections. This is still working well and is beginning to help the casualty departments in the various hospitals. A request was received during 1962 for the scheme to be extended so that general medical practitioners could be notified of any of their patients receiving tetanus injections in county council clinics, and this was done.

#### *Protection against Poliomyelitis.*

In February the Ministry of Health issued the first supplies of Sabin oral poliomyelitis vaccine to local health

authorities. For a few months many general practitioners continued to requisition Salk vaccine but the oral antigen soon replaced this almost completely. The offer of a fourth dose of this vaccine to school children aged 5-12 previously protected by three Salk injections continued during the year.

During the summer months, whilst the schools were on holiday, we took advantage of the free publicity material issued from the Central Office of Information and arranged special poliomyelitis vaccination sessions at the various clinics throughout the county. There was a reasonably good response to these, and many adults took advantage of the offer to commence a primary course of vaccination.

On 31st December, 1962, 92 per cent. of school children aged 5-15 years were protected against poliomyelitis by having received either 3 or 4 injections or doses, and a further 7 per cent, are partially protected by their first two doses.

### *Infectious Diseases*

The following table shows the notifications of infectious diseases in school children during the year. It is gratifying to note that no cases of poliomyelitis, or diphtheria have been reported. The number of notifications of all diseases has declined during the year, with the exception of measles and pulmonary tuberculosis.

*Cases of Infectious Diseases in children of School Age.*

	Scarlet Fever	Whooping Cough	Measles (Excluding Rubella)	Dysentery	Meningococcal Infection	Ac. Pneumonia	Food Poisoning	T.B. Respiratory	T.B. Meninges & C.N.S.	T.B. Other	TOTAL
URBAN											3
Cockermouth	—	—	1	—	—	—	—	2	—	—	—
Keswick	—	—	—	—	—	—	—	—	—	—	162
Maryport	2	—	158	1	—	1	—	—	—	—	127
Penrith	—	—	127	—	—	—	—	—	1	—	183
Whitehaven	—	—	182	—	—	—	—	3	—	—	309
Workington	4	—	300	—	1	1	—	—	—	—	—
RURAL											4
Alston	—	2	—	2	—	—	—	—	—	—	—
Border	5	5	14	12	—	1	—	—	—	—	37
Cockermouth	4	—	120	9	—	—	—	—	—	—	133
Ennerdale	2	1	109	—	—	—	1	—	—	1	114
Millom	—	—	58	6	—	—	—	—	—	—	64
Penrith	1	—	23	3	—	—	—	—	—	—	27
Wigton	2	5	85	20	—	1	—	—	—	—	113
	20	13	1177	53	1	4	1	5	1	1	1276



The year 1962 did provide a sharp reminder of the ever present risk of the introduction of smallpox into the country. I trust that, since in 1962 more than half of the children under one year were vaccinated against smallpox, the trend in this uptake rate will continue to be upward and so ensure a better protected school population.

I have already mentioned the universal introduction of pre-sterilised disposable syringes for all immunisation work carried out by county staff. One of the very important factors concerned here is the elimination of serum transmitted hepatitis. Infective hepatitis is an ever recurring problem and it is well established that it is not infrequently, though by no means always, transmitted by multiple use of syringes or by inadequate sterilisation.

Dr. Smith reports on a small outbreak of this disease which occurred at the end of 1961 and beginning of 1962.

"There was an outbreak of this disease at Heskett Newmarket between October, 1961, and February, 1962, centred on the village school. The first case was in an adult and symptoms started on 12th October with jaundice developing a week later. Two children in the family had slight symptoms commencing on the 20th when the schools closed for a week. They returned to school when it re-opened on the 30th.

Between 14th November and 21st November, eight cases of clinical infective hepatitis occurred among children attending Heskett Newmarket School. One of the two teachers developed the illness on 8th December and another child on 11th December. Three more children became infected between 20th and 22nd December.

Enquiries were made at the homes of the children. In several cases other members of the family had developed a mild illness without jaundice usually about three weeks after the school child became ill. In only two families did further cases of jaundice occur and these two families were related and occupied neighbouring farmhouses. Between these two families nine further cases occurred.



Between 26th January and 13th February, four further cases occurred in children attending the village school but three of them belonged to the families mentioned above and the source of the infection was as likely to be the home as the school.

Infective hepatitis is a disease of varying severity and occurs chiefly as sporadic cases or small family outbreaks. Larger outbreaks have been chiefly reported from rural areas. The incubation period is usually long, two to six weeks, but in this outbreak a period of around three weeks was the rule from the development of symptoms in a case to the development of symptoms in a contact. All the evidence would seem to indicate case-to-case spread. Most children have meals at the school canteen but there was nothing to indicate that infection occurred there. The village has a very poor water supply, both in quality and quantity, but here again the epidemiological evidence was against water borne spread. The school has outside water closets which are well maintained. Washing facilities with hot and cold water are within the school building and thus remote from the water closets. This is an unsatisfactory feature of a great many schools and could be a factor in the spread of this disease and others such as *sonne* dysentery which is becoming increasingly prevalent".

### *Swimming Baths*

It is becoming increasingly popular for schools to install swimming pools, mainly by the efforts of parent-teacher organisations, and 4 such pools are now in use in the county. Two are of the prefabricated Purley Pool type, and one has been installed by parents and teachers as a more permanent feature. The first swimming pool to be built in as a permanent feature of a new school came into use at Solway School, Maryport in September, 1961.

The supervision of the hygiene of these pools has produced some interesting problems. Very soon after the permanent pool at Solway School came into use, samples of

water began to be reported as unsatisfactory by the bacteriological laboratory. Despite adjustment of the bathing load and the quantities of chemicals added for purification, it has not been possible to achieve consistently satisfactory bacteriological samples of water, even in some instances when the pH and residual chlorine readings were satisfactory. These latter have been simultaneously checked by the hospital biochemistry laboratory and this problem remains something of a mystery. The Royal Society of Health expert panel have given advice recently and further recommendations have been made by the firm supplying the chemicals used in the purification and filtration plant. It is hoped that this will lead to a solution of the problem, but I feel that it may be necessary in the long run to reconsider the 10 hour turnover period of the water with the present plant.

Water samples from the smaller outdoor pools have, in the main, been satisfactory, and the possible risks of contamination and consequent effects on water purity have been carefully guarded against. Dr. Smith has contributed the following comments on the working of a small prefabricated pool at one of the schools in his area.

“A Purley type swimming pool was installed at St. Andrew's Boys' School, Penrith, in 1961. It is a wood and plastic structure and the water can be treated by continuous filtration and chlorination while the pool is in use. The water is 2 ft. 6 ins. in depth and the staff find it is a popular and safe method of teaching the children to swim. Unfortunately, due to poor weather, the pool has had very little use, and last summer there were only 15 occasions when it could be used.

From the public health point of view the pool appears to be hygienic. There is a plastic cover to prevent any contamination when not in use. There are only two possible objections. Firstly the water is chlorinated before filtration when it would be sounder to do so afterwards. Secondly there is a great temptation to overload the pool on the few

days that the weather is suitable. While there is no objection to a class of 30 using the pool at one time, relays of classes would soon overload the filtering and chlorinating apparatus.

Two methods of testing are available. The first is a portable apparatus which can be used in measuring the free and combined chlorine, and this is used frequently by the staff when the pool is in use. Samples can also be taken for bacteriological analysis. Even after a full afternoon's continuous use of the pool, satisfactory bacteriological results were obtained, no B coli type 1 or coliform organisms being present in a 100 ml of water.

It is hoped that the pool will get more use this summer, and that further testing will prove the soundness of the apparatus for filtration and chlorination".

## HEALTH EDUCATION

The aim of health education is to promote the best possible use of the inherited powers of body and mind, and to ensure the happy adjustment of the individual to the ever-changing needs of society.

There have been sweeping changes over the last thirty years in the type of health education that is required. In this connection it is of interest to look at a report by a school nurse who has been engaged in this field of work over that long period. Mrs. Knudtson, who has been a school nurse in the Workington area for 33 years, comments on the changes that have occurred.

“At a medical inspection in the pre-war period the common conditions were bronchitis, pigeon chest, knock knees, otorrhoea, squints and enlarged tonsils, and malnutrition in addition to bone and joint deformities as a result of tuberculous infection. Some children were in school barefoot and many were poorly clad.

Eye and ear conditions then cost money to be seen by a specialist, and where the parents could not pay, the children depended on having the fee paid by the Borough Education Committee. Only four children were allocated per month with the result that the waiting list mounted. The coming of the National Health Service changed all this.

In the 1930's many school children were verminous. Not only were their heads affected but some also suffered from impetigo. Those who are mothers and fathers today can tell me how miserable they were and yet how they were expected to learn. Today it is common to visit a school for a cleanliness inspection and find less than one child in a hundred with nits, and impetigo of scalp is rarely encountered. Flea bites are equally rare.

Education at many levels, and the showing up of a need which has been filled at local and later national level, has led to the well nourished, happy, school child of the 1960's.



With the co-operation of the teaching staff it was made possible for me to visit every school in the borough weekly, and then the homes were visited. Health education in a friendly kindly way, was the only way to impress the people. In the early days it was possible to give only advice at home and later, often many visits later, the mother would consent to the child going along to have something put on her head. With improvement, regular visits to the clinic became accepted and advice on other topics would be sought and given.

The vast improvement in nutrition began to appear in the days when one headmistress arranged for a cup of hot cocoa to be available at a halfpenny a time. Meals were in fact available free for children in poor circumstances but there was reluctance to accept these. Here again home visits to mothers produced results when it was explained that the meals, though free, had been paid for already. From the early 1940's meals were available in the town, originally in one centre run by local ladies. Today each school has its own canteen.

New procedures necessitated visits to educate mothers. Diphtheria immunisation was introduced in the early 1940's and immunisation against poliomyelitis in the late 1950's. In the case of diphtheria the persuading was more at a local level. Someone in the same street developed the disease and the risk could be brought home. In the case of polio it needed the death of a footballer to persuade people of the necessity for protection.

But through all the foot-slogging — there were no cars in the early years for school nurses — the recurring theme has been cleanliness. In spite of all the new houses and hygiene measures, it is still very necessary to visit schools frequently and keep in touch with the mothers by visiting the homes.

It has been a long term programme. My school children of the past are parents today with their families, and it is very gratifying to see how differently their children are being cared for and how eager they are to seek advice".



We can see from this report the great improvement in the health of the community which has been affected by the radical changes in the public health and social services over the past thirty years. There is still much work to be done, however, to ensure that this improvement reaches every member of the community.

The creation of a healthy way of life, therefore, still depends very much on the individual, and health educators much attempt to formulate very early in the child's life the basic standards of healthy living. Health education of the school child has become an essential factor in the drive to produce a healthy society.

What, then are we as a team doing to educate, not only the school child, the parent of tomorrow, but also the parents and prospective parents of the present day?

In this county the school nurses and health visitors continue to pay regular visits to their schools, giving group talks on all aspects of personal hygiene, minor injuries, coughs and colds, food values, posture and smoking.

It is not uncommon following a hygiene inspection in school for a nurse to report a number of children with nicotine staining on the fingers.

Flannelgraphs, posters, blackboard work, projectors and film strips are in constant demand.

One talk was given at a swimming bath on foot care and foot wear following a complaint received about veruccae. One nurse, following a talk in school, found the mother telling her of the effects of her talks on the children. The demand for sweets had fallen, while the demand for tooth brushes had increased. Another mother complained of having to buy new shoes for her daughter, who wanted the type recommended by the school nurse in her talk.

Mrs. Maughan, a health visitor/school nurse gives the following account of her activities in schools.

"I have found the most effective method of teaching health education in the country schools is by the use of flannelgraphs.

In the smaller schools it is possible to congregate all the children into one classroom. The headmasters are very co-operative in this connection and let me have the use of a suitable blackboard on which to place the blackcloth.

I then try to give each child the opportunity to place at least one item on the blackcloth. If an item is wrongly placed, one of the pupils quickly spots the mistake and this often leads to a lively discussion.

"Accidents in the Home" is a very popular flannelgraph and on occasions I have known the children be so interested that the completion of it and the discussion afterwards has lasted over an hour.

The use of personal dental hygiene flannelgraphs can be very well introduced at the time of the routine hygiene inspection. These too are very well received and some of the mothers have subsequently commented favourably on this method".

On her efforts in secondary modern schools Miss Knibbs makes the following contribution.

"At the request of the headmaster I go into the secondary modern school for three talks to school leavers. The syllabus covers "Basis for Beauty" (e.g. diet, posture, etc.), "Care of Skin, Teeth and Feet", and instruction in adolescent hygiene. Flannelgraphs have been used in demonstrations and illustrations in popular magazines on posture, fresh air, clothing and diet.

The shops have been most co-operative in lending me such articles as foundation garments and toilet requisites in which the girls have been very interested. Discussions that follow I feel are useful and helpful to the girls".

Undoubtedly the outstanding single subject which has figured in my thoughts during 1962 has been the matter

of smoking in schools, and I would like to be able to report as much progress here as there had been thought. This is unfortunately not possible although a not inconsiderable effort has been made by school medical officers to make an impact on this singularly obstinate problem. All of the school medical officers have to some extent been engaged in giving talks and trying to stimulate discussions amongst the younger children in secondary schools. While the reception often seems favourable at the time, the final assessment of the effect is notoriously difficult. Dr. Spencer writes as follows of her work in this field.

“A start has been made in the campaign to discourage school children from smoking.

It was decided to present the dangers of smoking by short talks and a film strip, leaving time for a discussion and questions. The children addressed were between the ages of eleven and eighteen in the following schools:—

Victoria Girls, Workington	... ..	5 talks
Newlands Secondary Modern, Workington		3 talks
Whitehaven Grammar School	... ..	2 talks
Richmond Secondary Modern, Whitehaven		1 talk

The parent teacher association at Newlands Secondary Modern was also addressed one evening.

The number of talks given depends on the size of the room available, and the numbers of the audience, and it is hoped to revisit some of the above schools so that all children over eleven years old may be instructed.

The response in general interest and questions asked was good, and the head teachers were most helpful both in the organisation and in leading the discussions and questions.

Two other schools in the Whitehaven and Cleator Moor area have asked for similar talks and it is hoped that many more head teachers will approach the health department about this very important topic.”

Dr. Patterson has approached the subject from a slightly different angle — he secured the use for a period of the film "Spotlight on Smoking" and has visited a series of schools using this film as the basis of his health education. I quote from his account of this venture.

"The connection between smoking and lung cancer and chest diseases such as bronchitis is recognised and accepted by all who can see the problem objectively. The majority of those more closely involved, i.e. those who have the habit of smoking, cannot accept it mainly because they do not wish to. The third group, who may or may not accept it, is composed of those who have not yet begun, or are just beginning to smoke, and these are our special concern. The schoolboy smoker of today will become another possible victim of lung cancer twenty years hence.

It is agreed that action must be taken now, the only problem being the best and most suitable technique to be used. The simplest technique is clearly to use television to put over the facts and to keep reiterating the dangers. Here there is a captive audience containing the majority of those aged 10-16 years.

The first effort was made during school medical inspection, when a small group of five or six pupils were assembled for examination. The facts were simply put before them in a conversational way, but there did not seem to be any response. The same lack of results was obtained when talking to individuals singly. It was like speaking to someone who would accept whatever you had to say as being true, simply because you said it. Questions were few, and after a time one felt as if knocking one's head against a stone wall, with the resulting loss of conviction on the part of the educator. The pupils seemed to be overawed when singled out, even in a small group, and the impression given seemed to be that they would accept what was said just as they would accept a lecture from the headmaster or a clergyman; but to them it was simply talk.



The next technique tried was the showing of sound film. Here the pupils were assembled, a short introductory talk of about 2 minutes given, the film run for about 20 minutes followed by questions and answers. This seemed to be successful in that it seemed to get through to the children judging by the questions and talk which followed. It certainly was more satisfying to the person trying to put the ideas across.

The film used was the B.B.C. telerecording "Spotlight on Smoking". This is a 16 mm. sound black and white film. As it could be borrowed only for a limited period, it was decided to spend one whole week doing this during school hours.

Co-operation of the school staff was excellent, the excitement caused by the break in the school routine seemed to stimulate the interest of the children and probably made the event and its subject have a more lasting impact than a talk alone would have had. Accompanied by an administrative colleague from the health department I travelled several hundred miles from Monday at 9 a.m. until Friday at 4 p.m. and showed the film in 19 schools. At the larger schools a continuous programme lasting a morning or afternoon was used, and in all the film was shown 25 times.

The film interested the children because they saw and heard other children expressing views on the subject, recognised several sporting and teenage idols, and were impressed by the dramatic use of animals. Facts and figures were kept to a minimum.

Questions followed the film to a much greater extent than followed a talk. There were pertinent questions. The one most common in the secondary schools was 'How do I stop smoking?' At the secondary schools I announced before the film that I would be available for questions at the back of the hall so that children could ask their questions on their way out without the embarrassment of standing up in front of 200 other children. This seemed to be a good thing and the questions ranged from 'Do you smoke?' to 'You are only trying to frighten us'.



The commonest question in the junior schools was not a question but a statement: 'My mum smokes' or 'My dad smokes', and it was repeated so often that I began to realise that it was really a question. It meant 'What do I do now if it is so serious for them?' I have since talked to some of the parents and they remarked on how their children have since reminded them when they smoked of the danger.

Whether this will have any lasting effect on some of the children it is hard to say but at one country school where the headmaster pointed out a ten year old who had smoked for quite a time, I made a point of observing him during the film. He certainly looked worried a few times and especially when he saw the results of nicotine poisoning on a mouse. As we left he was standing at the door with a very strained look on his little pale face! The message certainly got through to him.

It would seem that we are using the children to educate their parents rather than the parents teaching their children the evils of smoking.

Since that time I have had talks with the head teachers who have noted a decrease in the amount of smoking in their school not only amongst the children, but amongst the staff.

Until someone produces a more effective technique, this is the one I will continue to use, but it must be used fairly regularly as the memories of the susceptible age group are very short. The only limiting factor here, apart from the time taken will be the supply of suitable films".

That an epidemic of cancer of the lung (not to speak of the other conditions associated with cigarette smoking) lies ahead, there can be no reasonable doubt. This being so it is my intention to ensure that school medical officers and school nurses do their utmost to keep the danger of cigarette smoking before school children.

## RELATED SERVICES

### *Medical Examination of Teachers*

The following medical examinations took place during the year:—

Entrants to Training Colleges	...	148
Entrants to employment as teachers by Cumberland Education Committee		134

In order to assess the results of the medical examination of all teachers taking up superannuable appointments, a survey of teachers appointed during the school year 1961/1962 showed that, of 136 examined, 6 were referred for specialist opinion before their appointments could be confirmed.

This has led to consideration as to whether it would be adequate to have a questionnaire completed by the candidate, together with the submission of a satisfactory chest X-ray report within the last twelve months.

At the time of writing this report, this matter is under active consideration and it is hoped that a revised scheme will come into operation shortly.

### *School Premises*

Mr. Gordon S. Bessey, Director of Education, has supplied the following note on developments in regard to school premises:—

"New premises were provided for Boltons C. of E. School, the new premises for Distingon Infant School were completed (i.e. second instalment erected) and the new Hensingham Junior School was completed (i.e. second instalment added). An instalment, the infant wing, of Garth Primary School, Salterbeck, was opened and a second instalment of extensions (an eight storey block) to the Workington College of Further Education was completed.

Minor building projects to the value of over £77,000 were begun on site to improve or extend teaching and ancillary accommodation and to develop playing fields".

In this connection one matter which has given me some concern during the year is the number of schools which still have less than satisfactory sanitary accommodation. At the time of writing this report detailed discussions are taking place with Mr. Bessey on those areas where this problem is particularly troublesome, in the hope that a significant improvement can be brought about in the near future.

### *School Meals*

Mr. Gordon S. Bessey has supplied the following report on the School Meals Service, together with the note on Milk in Schools, which follows:—

“Once again, during the year 1962, a hot mid-day meal was available for children attending each of the 282 nursery primary and secondary schools maintained by the authority. As was the case during the previous year, the percentages of children taking dinners at both primary (including nursery) and secondary schools on a day in September showed increases, while the overall percentage at all schools again reached a record, namely 72.8%. The figures for that day as compared with those for a day in September, 1961, are set out below.

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals	Number of children present	Number taking meals	Percentage taking meals
1962	20,353	13,708	67.4	14,996	12,041	80.3	35,349	25,749	72.8
1961	20,720	13,518	65.2	15,172	11,800	77.8	35,892	25,318	70.5

During the year under review, a new infant school at Distington and an instalment at Workington, each with appropriate meals facilities, were completed. Distington Infant School, which includes a 75 meals kitchen, opened on 23rd July, while Garth School at Salterbeck was taken into use on 19th June. At present, the latter school has only temporary scullery facilities and meals are sent from Stainburn.

Central Kitchen pending the erection of the second instalment which will include a kitchen.

New premises for Boltons C. of E. School, including a 40 meals kitchen, were completed during the early part of the year, and also occupied on 19th June. Hitherto, container meals for children at the old school had been sent from Wigton Central Kitchen.

By the end of the year new premises for Scotby School and the third and final instalment of Thursby School (each including a kitchen, of 40 and 100 meals per day capacity respectively, and suitable dining space) had been virtually completed and it is anticipated that they will be occupied during the early weeks of 1963. Meals facilities at both schools will then show a considerable improvement since, at present, they are provided with container meals from Wetheral School Kitchen and Wigton Central Kitchen respectively. Furthermore, the Thursby children walk some distance to their dining centre in the old school premises.

Following the vacation of the former Solway House premises by the secondary school at the end of the Autumn term 1961, the HORSIA classrooms were occupied by Maryport Nursery School on 25th June, 1962. Part of one of them was immediately taken into use for dining purposes, meals being supplied from Maryport Central Kitchen. Shortly afterwards a further portion was adapted to form a 40 meals kitchen which began producing meals on 5th November.

In order to relieve congestion at the Congregational Church Rooms Dining Centre, children in attendance at the County Girls' School, Penrith, began to dine in a former housecraft room at their own school on 13th June, 1961. During the Autumn of 1962 conditions were much improved by the substitution of modern washing up facilities for the old and inefficient equipment formerly in use.

Since 3rd September, dinners have been served in Burghley-Sands School and St. James' C. of E. Junior School, Whitehaven, thus enabling the use of rented accommodation to be continued.



## Milk in Schools

The figures given below show the consumption of milk by day pupils present at the 282 nursery, primary and secondary schools maintained by the authority on a day in September, 1962, as compared with a day in the same month in 1961:—

Year	Primary and Nursery Schools			Secondary Schools			All schools combined		
	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk	Number of children present	Number taking milk	Percentage taking milk
1962	20,353	18,508	90.0	14,996	8,389	55.9	35,349	26,897	76.1
1961	20,720	18,781	90.6	15,172	7,828	51.6	35,892	26,609	74.1

The most pleasing feature about these figures is the reversal of the trend in recent years towards a decline in milk drinking in secondary schools.

The following table shows the percentages of different types of milk being supplied to children attending maintained day schools in September, 1962, the corresponding figures for 1961 being shown in brackets:—

Pasteurised	...	...	80.9% (73.0%)
Tuberculin tested	...	...	19.1% (27.0%)

## Physical Education

I am indebted to the Chief Organisers of Physical Education, Miss Kathleen Sutton and Mr. Lionel Heyworth for the following report:—

“Increased competition in international trade, improvement in industrial techniques and automation, will bring in their wake substantial additions to leisure time, and it is possible in the lifetime of pupils now at school that the 30 hour working week will be achieved. Such personal freedom will throw responsibilities upon the individual to ensure that new found leisure is fully utilised in a profitable and healthy manner.”

giving way, and upon the community to provide facilities and training to enable the free time to be so used.

Education and training should be geared to future needs in order that pupils may be equipped to meet social and emotional challenges as these arise, and so led along the road to positive health. In the application of these principles it is a fundamental aim of physical education to encourage people by the time they reach adult life to have selected for themselves one or more forms of physical recreation which satisfy their basic human needs.

The evidence of the last decade, drawn from universities, colleges, clubs and schools, points to a reduction in the numbers of young people electing to follow traditional games as personal physical recreation. It would appear that in the years ahead this group will be confined to those members of the community who have shown special aptitude for competitive national sport at school, and that attention should be directed to the needs of young people and adults who are neither games minded nor gregarious, and for whom traditional sport has not a personal appeal, but who still require physical recreation providing challenge, self reliance, relaxation and social opportunity. It is visualised that while the village football and cricket club may tend to decline, these sports becoming centralised through reduced demand and ease of transport, the demand for facilities for athletics, badminton, golf, tennis, squash, swimming, dancing, fencing, judo and open country pursuits of all kinds where physical recreation may be followed in mixed company, small groups or individually, will increase. In this type of physical recreation, challenge and effort may be controlled directly by the participant, either at will or by selection of the companions who take part with him.

It should not be assumed, however, that the demand for playing field space will not be maintained, indeed it will tend to increase in centralised situations where these are accessible from a large area, and where leisure time is extended. It is

foreseen that full use will be made of the 392 acres of school playing field now under maintenance by the authority and that the all-weather pitches now being constructed will provide a safety valve for the heavy demands which will be made upon educational facilities during the next decade. The Cumberland and Westmorland Playing Fields Association have been considering over the past two years the changing pattern of demand for recreational facilities, and have drawn the attention of the National Association to the evolution in leisure. The Lake District Planning Board have been invited to take part in a conference of out-door pursuits associations, which is designed to assess their particular requirements in the Lake District, not only for Cumbrians, but also for visitors coming in increasing numbers, to make use of the countryside so that the maximum advantage may be taken of mountains, lakes and rivers, with the minimum inconvenience to the residents and danger to the users.

If, upon attaining adult years, a rich and full life is to be enjoyed, the foundations of education for living must be laid at school. Here the future responsible citizen must gain the breadth of experience which will enable him to make the best advantage of the opportunities for physical recreation which lie ahead. It is at school that the basic social lessons of personal endeavour, co-operation, service, leadership, tolerance, reward and gratitude are learned, to be carried through into the youth field in preparation for adult life. In this context, time spent with teachers outside the confines of the school building, preferably in residence, where the impact of personality can be best obtained, has the greatest contribution to make to social education, where physical recreation becomes the vehicle for a much deeper purpose. Cumberland teachers, being aware of the importance of this reflected education and the need for personal competence in games, have continued to support voluntary county courses in netball, hockey, athletics for girls and young women, association football, rugby union football, rugby league football, cricket and athletics organised during the holiday periods or at week-



ends by schools' associations the last course, athletics, being arranged for boys for the first time at the County Youth Centre in March, under the direction of Mr. I. Ward, N.C.A.A.A. National Coach.

In order to broaden the horizons of Cumberland children in physical recreation, two new voluntary associations have been formed: the Cumberland Schools' Badminton Association and the Cumberland Schools' Gymnastic Association. "Spotlight upon Badminton" functions were arranged at Whitehaven College in January and at Wigton Secondary School in November, while the Cumberland Schools' Gymnastic Association organised a Boys' Gymnastic Championship at Lillyhall School in December. Inter-school fixtures in netball, hockey, cricket, football, rugby, athletics, cross-country running, tennis, basket ball, badminton and gymnastics have been held in increasing numbers during the year, aiming at school representation at all levels and thus catering for a larger number of boys and girls in a vital part of education. At district and county level, school representative fixtures have been held in association football, rugby union football (Twentyman of Wigton gaining international honours in the 19 Group, and 9 boys being selected recently for the 15 Group Northern Trial of the E.S.R.U.), rugby league football, cricket, swimming and athletics.

Being aware of the fertile ground for leisure presented by open-country pursuits and of the rich growth in social training which may accrue therefrom if suitably guided, Cumberland teachers continue to extend the interest of boys and girls in canoeing, rock climbing, camping, ski-ing, fell walking and allied activities. Increasing use is being made of the Keswick Youth Centre and Hawse End, where parties of children and their teachers have the opportunity of living together, and of the social contact which can only come with residential education. Both teachers and pupils find this "off-lutly" approach to education most rewarding, where recreation and academic study blended with informality, provide signposts for absorbing interests in the years ahead. A follow-up



to this variety of school activity has led this year again to the Girls' Training for Adventure Course at Keswick, youth courses in ski-ing, rock climbing, canoe handling, white water canoeing and canoe rolling. The challenges presented by the Duke of Edinburgh's Award Scheme have been taken up enthusiastically by schools and youth organisations, and have resulted this year in 5 gold, 9 silver and 49 bronze awards. Teacher training courses during the year have been directed towards those activities which may be applied in the normal physical education programmes in school, in the Youth Service and in Further Education.

Meetings have been arranged with Parent Teachers Associations where talks on physical education have been given, illustrated by films of Cumberland children at work, followed by discussion. Every opportunity is taken to implement the policy of the authority to teach the child to swim, to save life and if time and facilities allow, to train for competitive swimming. Good results have been obtained in our outdoor pools, lakes and baths, and the award of County and Royal Life Saving Certificates up to Award of Merit standards have been most satisfactory this year. It is interesting to record that an outdoor pool was opened at Seascale School in September, this project being the result of the efforts of parents, teachers and pupils.

The development of physical recreation in life is a continuous process and at each level, teachers and leaders will make some contribution to the moulding of the personalities for whom they are responsible. The dynamic appeal to young people of this aspect of education, places the teachers of physical education in a prominent position of influence for good or ill, for, during his progress through school, each child will gain something from his contact with the teacher's personality. Their influence will undoubtedly help him along the road to positive health, and their encouragement and guidance will support him in the years ahead, in coming to terms with his environment.

It has been very pleasing this year to welcome training college and university lecturers and organisers from Australia, Canada and the United States, and most interesting and stimulating to go with them to schools in Cumberland and to discuss our aims, training methods and the approach to the teaching of physical education.

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## **APPENDIX A**

### **MEDICAL INSPECTION AND TREATMENT**

#### **Part 1—Medical Inspection of Pupils attending maintained Primary and Secondary Schools (Including Nursery and Special Schools)**

##### **Table A—Periodic Medical Inspections**

PHYSICAL CONDITION OF PUPILS INSPECTED				Pupils found to require treatment (excluding dental diseases and infestation with vermin)				
Age Groups inspected (By year of Birth) (1)	No. of Pupils Inspected (2)	No. (3)	Satisfactory % of Col. 2 (4)	Unsatisfactory No. (5)	% of Col. 2 (6)	For	For any other	Total Individual pupils (9)
						defective vision (excluding squint) (7)	condition recorded at Part II (8)	
1958 and later	62	62	)			5	5	10
1957	1497	1496	)	1	.02	71	95	166
1956	1701	1701	)			61	128	186
1955	280	280	)			14	14	27
1954	59	59	)			4	3	7
1953	31	31	)			1	1	2
1952	3182	3181		1	.03	124	122	242
1951	856	856				31	37	67
1950	103	103				6	1	7
1949	48	48				6	2	7
1948	3285	3285	100			171	83	244
1947 and earlier	1443	1443				66	47	113
TOTAL	12547	12545	—	2	—	560	538	1078

*Table B.—Other Inspections*

Number of Special Inspections	...	5,515
Number of Re-inspections	... ..	7,502
Total	...	13,017

*Table C.—Infestation with Vermin*

(a) Total number of individual examinations of pupils in schools by school nurses or other authorised persons	... ..	69,439
(b) Total number of individual pupils found to be infested	... ..	1,406
(c) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	... ..	—
(d) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	... ..	—



Table D.—Screening Tests of Vision and Hearing

1. (a) Is the vision of entrants tested? ...	Yes.
(b) If so, how soon after entry is this done? ...	Within 12 months.
2. If the vision of entrants is not tested, at what age is the first vision test carried out? ...	—
3. How frequently is vision testing repeated throughout a child's school life? ...	Entrant, 8 yrs., Intermediate, Leaver.
4. (a) Is colour vision testing undertaken? ...	No (only if suggested for special reason).
(b) If so, at what age? ...	—
(c) Are both boys and girls tested? ...	—
5. By whom is vision and colour testing carried out?	School medical officers and school nurses.
6. (a) Is audiometric testing of entrants carried out? ...	Yes.
(b) If so, how soon after entry is this done? ...	Within 12 months.
7. If the hearing of entrants is not tested, at what age is the first audiometric test carried out? ...	—
8. By whom is audiometric testing carried out? ...	Audiometrician.

**Part II—Defects found by Medical Inspection during the year**

**Table A—Periodic Inspections**

Defect Code No.	Defect or Disease	PERIODIC INSPECTIONS							
		Entrants		Leavers		Others		Total	
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
4	Skin ...	7	77	23	113	32	164	62	354
5	Eyes—a. Vision ...	136	375	172	519	254	885	562	1779
	b. Squint ...	20	49	—	29	10	76	30	154
	c. Other ...	7	12	9	26	12	30	28	68
6	Ears—a. Hearing ...	14	142	2	36	21	89	37	267
	b. Otitis Media ...	7	5	2	26	6	49	15	80
	c. Other ...	4	32	—	4	9	16	13	52
7	Nose and Throat ...	52	332	3	71	22	248	77	651
8	Speech ...	31	65	3	11	12	46	46	122
9	Lymphatic Glands ...	11	58	1	7	4	24	16	89
10	Heart ...	3	46	2	41	2	83	7	170
11	Lungs ...	5	153	2	73	16	138	23	464
12	Developmental—								
	a. Hernia ...	5	13	3	1	5	9	13	23
	b. Other ...	1	36	6	29	7	124	14	189
13	Orthopaedic—								
	a. Posture ...	1	4	5	11	5	18	11	33
	b. Feet ...	33	65	5	20	25	57	63	142
	c. Other ...	21	141	11	65	30	127	62	333
14	Nervous System—								
	a. Epilepsy ...	—	10	1	8	1	13	2	31
	b. Other ...	1	10	1	3	1	11	3	24
15	Psychological—								
	a. Development ...	—	24	—	48	8	74	8	146
	b. Stability ...	5	38	1	10	5	38	11	86
16	Abdomen ...	2	28	1	23	5	69	8	120
17	Other ...	19	47	5	60	15	134	39	251
	Menstruation ...	—	—	—	6	—	6	—	12

**Table B.—Special Inspections**

				SPECIAL INSPECTIONS	
Defect Code No.	Defect or Disease		Pupils requiring Treatment	Pupils requiring Observation	
(1)	(2)		(3)	(4)	
4	Skin	... ..	555	63	
5	Eyes—	a. Vision	167	350	
		b. Squint	3	6	
		c. Other	86	25	
6	Ears—	a. Hearing	9	50	
		b. Otitis Media	1	14	
		c. Other	20	6	
7	Nose and Throat	... ..	8	53	
8	Speech	... ..	14	30	
9	Lymphatic Glands	... ..	3	5	
10	Heart	... ..	—	3	
11	Lungs	... ..	1	33	
12	Developmental—				
		a. Hernia	—	2	
		b. Other	—	5	
13	Orthopaedic—				
		a. Posture	—	—	
		b. Feet	3	13	
		c. Other	6	26	
14	Nervous System—				
		a. Epilepsy	—	3	
		b. Other	—	2	
15	Psychological—				
		a. Development	7	31	
		b. Stability	1	18	
16	Abdomen	... ..	1	15	
17	Other	... ..	178	70	

### Part III—Treatment of Pupils attending maintained Primary and Secondary Schools

(Including Nursery and Special Schools)

**Table A.—Eye Diseases, Defective Vision and Squint**

Number of cases known  
to have been dealt with

External and other, excluding errors of refraction and squint	...	...	87
Errors of refraction (including squint)			2,957
			<hr/>
Total	...	...	3,044
			<hr/>
Number of pupils for whom spectacles were prescribed	...	...	1,631

**Table B.—Diseases and Defects of Ear, Nose and Throat**

Number of cases known  
to have been dealt with

Received operative treatment—			
(a) for diseases of the ear	...		9
(b) for adenoids and chronic tonsillitis	...	...	81
(c) for other nose and throat conditions	...	...	32
Received other forms of treatment	...		56
			<hr/>
Total	...	...	178
			<hr/>
Total number of pupils in schools who are known to have been provided with hearing aids—			
(a) in 1962	...	...	10
(b) in previous years	...	...	45



**Table C.—Orthopaedic and Postural Defects**

			Number of cases known to have been treated
(a) Pupils treated at clinics or out- patients departments ... ..			1,132
(b) Pupils treated at school for postural defects ... ..			—
			<hr/>
Total ... ..			1,132
			<hr/>

**Table D.—Diseases of the Skin**

(excluding uncleanliness, for which see Table C of Part I)

				Number of cases known to have been treated
Ringworm—(a) Scalp ... ..				1
(b) Body ... ..				13
Scabies ... ..				3
Impetigo ... ..				60
Other skin diseases ... ..				540
				<hr/>
Total ... ..				617
				<hr/>

**Table E.—Child Guidance Treatment**

	Number of cases known to have been treated
Pupils treated at Child Guidance clinics	424

**Table F.—Speech Therapy**

	Number of cases known to have been treated
Pupils treated by speech therapists ...	591

**Table G.—Other Treatment Given**

	Number of cases known to have been dealt with
(a) Pupils with minor ailments ...	213
(b) Pupils who received convalescent treatment under School Health Service arrangements	138
(c) Pupils who received B.C.G. vaccination ... ..	2,206
Total (a)—(c) ... ..	<hr/> 2,557 <hr/>

**Part IV—Dental Inspection and Treatment carried out by the Authority.**

**(a) Dental and Orthodontic work:**

(1) Number of pupils inspected by the Authority's Dental Officers:—	
(a) at Periodic Inspections	27,861
(b) As Specials ... ..	265
	<hr/>
	Total 28,126
(2) Number found to require treatment	17,059
(3) Number offered treatment ...	13,422
(4) Number actually treated ... ..	12,208

**(b) Dental work (other than orthodontics.)**

(1) Number of attendances made by pupils for treatment, excluding those recorded at (c) 1 below ...	27,344
(2) Half days devoted to:	
(a) Periodic (School) In- spection ... ..	277
(b) Treatment ... ..	3,720
	<hr/>
	Total 3,997
(3) Fillings:	
(a) Permanent Teeth ...	15,615
(b) Temporary Teeth ...	1,392
	<hr/>
	Total 17,007

(4) Number of Teeth Filled:			
(a) Permanent Teeth	...	14,185	
(b) Temporary Teeth	...	1,355	
		<hr/>	Total 15,540
(5) Extractions:			
(a) Permanent Teeth	...	6,186	
(b) Temporary Teeth	...	10,231	
		<hr/>	Total 16,417
(6) Administration of general anaesthetics for extraction	...	...	3,662
(7) Number of pupils supplied with artificial teeth	...	...	361
(8) Other operations:			
(a) Permanent Teeth	...	6,282	
(b) Temporary Teeth	...	799	
		<hr/>	Total 7,081

**(c) Orthodontics:**

(1) Number of attendances made by pupils for orthodontic treatment			1,476
(2) Half days devoted to orthodontic treatment	...	...	185
(3) Cases commenced during the year			218
(4) Cases brought forward from the previous year	...	...	95
(5) Cases completed during the year	...		44
(6) Cases discontinued during the year			27
(7) Number of pupils treated by means of appliances	...	...	117
(8) Number of removable appliances fitted	...	...	131
(9) Number of fixed appliances fitted	...		

# APPENDIX B

## Handicapped Pupils requiring Education at Special Schools approved under Section 9(5) of the Education Act, 1944, or Boarding in Boarding Homes.

During the calendar year ended 31st December, 1962	(1) Blind (2) Partially sighted		(3) Deaf (4) Partial hearing		(5) Physically Handicapped (6) Delicate		(7) Maladjusted (8) E.S.N.		(9) Epileptic (10) Speech Defects		Total Cols. (1)-(10)	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
A. How many handicapped pupils were newly assessed as needing special educational treatment at special schools or in boarding homes? ... ..	—	—	2	1	2	—	—	43	—	—	48	
B. (i) of the children included at A, how many were newly placed in special schools (other than hospital special schools) or boarding homes? ... ..	—	—	2	1	—	—	—	4	—	—	7	
(ii) of the children assessed prior to 1st January, 1962, how many were newly placed in special schools (other than hospital special schools) or boarding homes? ... ..	1	—	2	1	2	—	—	15	1	—	22	
Total (B(i) and B(ii)) ... ..	1	—	4	2	2	—	—	19	1	—	29	

On or about 30th January, 1963, how many handicapped pupils from the Authority's area—



C. (i) were requiring places in special schools—Total											
(a) day	...	—	—	—	—	—	—	—	—	—	46
(b) boarding	...	2	—	—	1	4	—	—	—	—	145
(ii) included at (i) had not reached the age of 5 and were awaiting											
(a) day places	...	—	—	—	—	—	—	—	—	—	—
(b) boarding places	...	1	—	—	—	—	—	—	—	—	1
(iii) included at (i) who had reached the age of 5, but whose parents had refused consent to their admission to a special school, were awaiting—											
(a) day places	...	—	—	—	—	—	—	—	—	—	7
(b) boarding places	...	1	—	—	1	1	—	—	—	—	46
D. (i) were on the registers of (1) maintained special schools as											
(a) day pupils	...	—	—	—	—	—	—	—	—	—	2
(b) boarding pupils	...	—	2	1	—	2	—	—	1	—	88
(2) non-maintained special schools as—											
(a) day pupils	...	—	—	—	—	—	—	—	—	—	—
(b) boarding pupils	...	7	3	11	9	9	2	—	2	—	43
Total	...	7	5	12	9	11	2	—	3	—	133

Total (D(i) and D(ii))	...	7	5	12	9	14	2	—	85	3	—	137
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Total (D(i), (ii) and (iii))	7	5	12	9	14	2	—	85	3	—	137
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(i) in hospitals	...	...	—	—	—	—	—
(ii) in other groups (e.g. units for spastics, convalescent homes)	...	...	—	—	—	—	13
(iii) at home	...	...	1	—	6	—	8

## APPENDIX C

### SCHOOL HEALTH SERVICE CLINICS AS AT 31.12.62

(As mentioned earlier in the report, the actual school clinic work as distinct from special clinics, is being carried out either in conjunction with child welfare clinic sessions or as specially required as from 1st January, 1963).

#### ALSTON:

Dental—2nd and 4th Tuesdays—all day.

#### ASPATRIA:

Dental—1st, 3rd and 5th Mondays—all day.

Orthopaedic Aftercare—2nd Friday p.m., 4th Friday a.m.

Speech Therapy—Each Thursday p.m.

#### BRAMPTON:

Dental—Each Tuesday and Wednesday—all day.

Orthopaedic Aftercare—1st Tuesday a.m.

#### CARLISLE:

Dental—daily—all day.

At Eden and Caldew Schools alternate Mondays

Eye Specialist—Each Monday and Thursday a.m.

Orthoptic—Each Tuesday a.m.

E.N.T. Specialist—Monday p.m. as required.

Child Guidance—Each Thursday p.m.

Speech Therapy—All day Tuesday and Friday p.m.

Orthopaedic Aftercare—Each Tuesday p.m.

Orthopaedic Surgeon—1st Monday every odd month p.m., 1st Monday every even month a.m. and occasionally as required.

#### CLEATOR MOOR:

Dental—Each Monday and Wednesday—all day.

Orthopaedic Aftercare—2nd and 4th Tuesdays p.m.

Speech Therapy—Each Tuesday a.m.

#### COCKERMOUTH:

Dental—Each Tuesday, Friday and occasional Thursday—all day.

Eye Specialist—Each Tuesday a.m. except 4th Tuesday.

Orthopaedic Aftercare—1st and 3rd Wednesdays—all day.

Speech Therapy—Each Thursday—all day.

#### EGREMONT:

Dental—Each Monday and Friday—all day

Speech Therapy—Each Wednesday a.m.

Orthopaedic Aftercare—2nd and 4th Tuesdays a.m.

#### FRIZINGTON:

Dental—Each Tuesday—all day

#### KESWICK:

Dental—Each Monday and Thursday—all day

Speech Therapy—Each Tuesday p.m.

Orthopaedic Aftercare—4th Monday all day

Eye Specialist—Each 4th Tuesday a.m.

#### LONGTOWN:

Dental—Each Friday—all day.

#### MARYPORT:

Dental—Each Monday, Thursday and Friday—all day.

Speech Therapy—Each Monday a.m. and each Wednesday all day.

Orthopaedic Aftercare—1st and 3rd Tuesdays—all day.

Child Guidance—Each Monday p.m.

#### MILLOM:

Dental—Each Tuesday, Wednesday and Thursday—all day.

Speech Therapy—Each Thursday—all day.

Child Guidance—Thursday p.m. as required.

Orthopaedic Aftercare—3rd Monday a.m.

Eye Specialist—each 1st and 3rd Friday a.m.

#### PENRITH:

Dental—Each Tuesday, Wednesday, Thursday and Friday all day.

Speech Therapy—Tuesday a.m. Wednesday all day.

Orthopaedic Aftercare—2nd and 4th Wednesdays—all day.

Orthopaedic Surgeon—1st Monday every even month p.m.

#### SEASCALE:

Dental—As required.

Orthopaedic Aftercare—3rd Monday p.m.

#### SILLOTH:

Dental—Each Tuesday and Wednesday—all day.

Orthopaedic Aftercare—3rd Friday p.m.

#### WHITEHAVEN (Flatt Walks):

Dental—Daily—all day. 2nd Clinic, Wednesday—all day.

School—Daily a.m. with medical officer attending each Wednesday morning.

E.N.T. Specialist—Tuesday a.m. as required.

Eye Specialist—Each Monday, Wednesday and Thursday a.m.

Speech Therapy—Monday and Friday all day.

Orthopaedic Aftercare—Each Thursday all day.

Orthopaedic Surgeon—1st Friday every odd month a.m.

2nd Friday every even month a.m. and occasionally as required.

Child Guidance—Each Wednesday p.m. Each Friday a.m.

#### WHITEHAVEN (Mirehouse):

Dental—Thursday—all day.

#### WIGTON:

Dental—Tuesday, Wednesday and Thursday—all day.

Speech Therapy—Each Thursday a.m.

Orthopaedic Aftercare—3rd Friday a.m.



WORKINGTON (Stoneleigh):

Dental—Daily all day.

WORKINGTON (Park Lane):

Dental—Daily—all day.

School—Daily a.m. with medical officer attending each Tuesday a.m.

Speech Therapy—Each Monday and Friday all day

Orthopaedic Aftercare—Each Friday all day except 3rd.

Orthopaedic Surgeon—1st Friday every even month a.m.

2nd Friday odd month a.m., and occasionally as required.

Eye Specialist—Every Thursday a.m.

Child Guidance—Each Wednesday a.m.

